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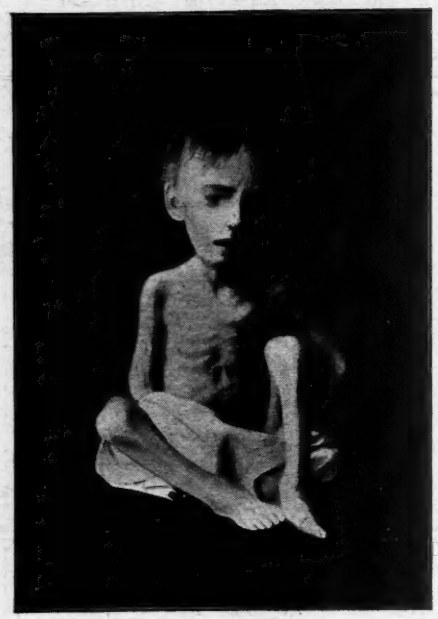

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After Virol.

9¼ lbs. gained in 5 weeks.

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THE MEDICAL JOURNAL OF AUSTRALIA.

VOL. I.—4TH YEAR. SYDNEY: SATURDAY, MARCH 10, 1917. No. 10.

MEDICAL EXPERIENCES IN THE WAR ZONE.[1]

By E. T. C. Milligan, M.D., B.S.,
Melbourne.

I regard it a great pleasure to be at this meeting to-night.

It is difficult to choose from the thrilling and sensational experiences of the last 2½ years something that could be related in a few minutes, and would at the same time be interesting.

I must pass over much that is supremely grand, much that is devilish, in the great tragedy that has been enacted in France.

Description from the ablest pen will fail to give to the mind a true picture, and, fortunately, human appreciation is unable to take in all its dreadfulness, pain and tragedy. The stimuli fall on senses already dulled by over-stimulus.

Peace values of life, death, action, aims and effort are changed by this war.

The thoughtful mind shrinks, often defeated, but nevertheless hopeful, before the perplexing problems of life which are daily present.

With all these things I will not deal, but will go on to practical things which concern us as men whose special calling in life is to prolong life and relieve suffering, to which duties the Army has added another, *viz.*, to send men back fit to the firing-line.

In all services of the Army there have been improvements and alterations, and this is very true of the medical services.

There are such changes in medical, surgical and administrative branches that nothing but the foundations which proved good and serviceable remain. The superstructure has entirely changed. I shall not touch the administrative branches, but will rapidly outline the changes in the surgical and medical departments.

The Treatment of Wounds.

When we set out for France in August, 1914, we were prepared to act on the lessons and experiences gained in the South African and the Russo-Japanese wars. These were conservatism in the treatment of wounds. Wounds healed readily, without energetic operative interference or vigorous antiseptic treatment, provided they were protected from further infection. Influenced by this teaching, handicapped by the large numbers of wounded and by proportionately few medical officers, we practised these methods at the battles of Mons, Marne, Aisne and Ypres. Iodine was used to combat the infection, and sterile dressings were used to protect the wound.

What were the results?

Shocking sepsis, tetanus and gas gangrene!

Tetanus was prevented by prophylactic doses of antitetanic serum, given to all wounded men. The course of the declared disease was favourably influenced by large doses of the same serum.

Gas gangrene, caused by the *bacillus aerogenes capsulatus* and the conditions caused by pyogenic organisms were not so easily nor so successfully dealt with, and much thought and careful work have been given to unravel the problems which present themselves, with the happy result that treatment is now on a more satisfactory basis.

In a modern projectile wound there is a varying amount of devitalized tissue bounding the wound and a varying amount of ingrained infected material, for the fragment carries in with it clothing, which, like the skin of the man, is seething with organisms of the most virulent type, derived from the alimentary tract of the soldiers themselves and the richly manured earth of France into which they have dug themselves. The devitalized tissue varies from a microscopical amount to the gross, obvious slough. The ingrained infected material is inseparably fixed to and distributed over the wound. The retraction of severed muscle fibres and the irregularly-shaped missile produces a wound the surfaces of which are pocketed and present crevices and crannies. No better surface and culture medium for the growth of organisms could be imagined, and, at the same time, the protective processes of the body are put at a great disadvantage.

The condition of affairs I have described seldom, if ever, exists in civil practice, for rarely are injuries produced by bodies with the momentum of a modern projectile, nor, fortunately, do we meet with such virulent organisms.

The treatment adopted at the present time can be summed up under two headings:—

(1) Excision of devitalized tissue, with removal of dirt and foreign bodies; and
(2) Antiseptic treatment.

Excision of devitalized tissue is followed in suitable cases by (1) secondary closure of the wound, (2) antiseptic measures.

Antiseptic treatment, and in deference to Wright, one should add physiological treatment, consists of the saline methods and the employment of hypochlorite solutions of Dakin and Lorrain Smith. It remained for Carrel, working with rare facilities for the French Army, to produce the most satisfactory results in wound treatment, and he did so by a combination of the excision of wounds with Dakin's hypochlorite solution. He removed dead tissue with a sharp scalpel, and, in so doing, left a wound bounded by a regular, smooth surface of healthy tissue. Fresh hypochlorite solution was then applied continuously to every part of the wound by means of carefully-arranged, small rubber tubes. By these means wounds were freed from organisms, some in a few days, and some after many days, the time depending on the severity of the wound and the tissue injured. Bones, muscles and irregular deep

[1] Read at a Meeting of the Ballaarat Division of the Victorian Branch of the British Medical Association on February 8, 1917.

wounds take longer than wounds of skin and superficial fascia.

The saline treatment of wounds and the so-called salt packs have their advantages. They are labour-saving, and require less skill in application, but the ideals aimed at are not so high. Pus *laudabile et bonum* is welcomed, whereas in the "excision-hypochlorite" method healing without pus formation is the aim.

Special Injuries.

Let me briefly touch on special injuries.

Head.—The majority of head injuries are fatal. Destruction of brain matter is the chief cause of death. Wounds from before backward, with entrance at the forehead or orbit, are very deadly. Hæmorrhage from injured cerebral arteries is frequently found spreading thinly over the surface of the brain; but compression is rare. Meningitis claims many victims from among those who do not die of shock or hæmorrhage. Patients who reach the Base Hospitals, on whom we hear operative interference is practised, are those with skull injuries with an intact or penetrated *dura mater* and with but little damage done to the brain. These cases have strikingly diminished since the men have been provided with steel helmets. The question whether the *dura mater* should be opened to release the pulped subjacent area of brain, or whether it should be preserved intact as a protection from a septic scalp wound, has divided the ranks of those interested in treatment. At first we did extensive decompression operations. Now, with better-trained powers of discrimination, there is much less operative interference in hopeless cases. They are recognized to be beyond the scope of legitimate surgery.

Compound Fractures of the Femur.—These are serious wounds, with a high mortality and morbidity. At first the long Liston splint was used for mobilization. This is rarely seen now. Its place is taken by the Thomas knee splint, and in the hands of Hey Groves transfixion for extension has given good results; but it is a method of treatment not without grave risks.

Joint Wounds present great difficulties. In the knee-joint we see all types of wounds, from the small, round, punctured wound to gross destruction of the component parts of the joint. Once tubes for drainage were inserted into the joint. This is now recognized as not good treatment. The following methods of treatment, used with discrimination and suitable indications, are now employed: (1) Aspiration and perfect fixation; (2) lavage with saline solution, injection of ether or formaldehyde; (3) exposure of the whole of the joint surface, with removal of cartilages and crucial ligaments; (4) excision of the knee-joint; (5) amputation of thigh.

Injuries to Arteries.—Comparatively few of these injuries are seen in wounded men. The presence of diffuse traumatic hæmatoma calls for incision and ligature above and below the wound in the artery. Circumscribed traumatic aneurysm and arteriovenous aneurysm are met with later on in the convalescence, and require suitable treatment. A wound of an artery is a serious complication, and gas gangrene often follows the injury.

Injuries to Nerves.—The common injury is contusion of nerves, with complete physiological division. Later on come the evils of pressure by callus and fibrous tissue. Sepsis forbids primary suture in anatomical division; but secondary suture and neurolysis is practised when sepsis is overcome. Rational splinting, massage and electrical treatment for the muscles affected is a most important part of the treatment in all cases of nerve injury.

Spine.—These injuries are perhaps the saddest we have to deal with, for often one finds a small, insignificant-looking punctured wound of the soft tissues in the region of the spine in a strong man, who has been rendered paraplegic, the small missile having wounded the cord. Operation is seldom attempted. The damage to the cord is done on the receipt of the wound, and we are unable to influence it by treatment.

Abdomen.—The treatment of abdominal wounds has changed from conservative treatment, *viz.*, rest and morphine, to active interference. By signs and symptoms peritonitis and hæmorrhage are diagnosed, and after the existing shock has been combatted, laparotomy is performed and the damage repaired and bleeding stopped. The diagnosis is often difficult. The operation is long and tedious. The shock is intense and difficult to treat successfully.

Chest.—For chest wounds expectant treatment is adopted. Interference is only called for in cases of pressure from hæmorrhage, and at a later date for empyema. Large perforating wounds of the chest wall, with total pneumothorax, still await successful treatment.

Amputation.—Two methods are adopted: the so-called guillotine method, in which skin, muscle and bone sections are flush, and the flap method, in which the flaps are stitched back and the raw surfaces of the stump left exposed. Both these methods are painful, inelegant, and require secondary operations. They are adopted as life-saving measures, since fatalities from gas gangrene followed the "set" amputations with immediate suture.

War Affections.

There are some new conditions which have appeared in the campaign. I will mention them briefly.

Trench Feet.—An œdematous, painful condition of the feet, due to impaired circulation, caused by cold, wet, lack of exercise and tight boots and putties. It rarely goes on to gangrene. It is controlled by exercise and frequent changes into warm, dry socks. Loose putties and boots are also essential.

Trench Fever.—This is a "scrap heap," where hitherto unknown febrile conditions are now thrown. Work is at present in progress to unravel the various types. One type is a relapsing fever, with limb pains and enlarged spleen. Another is a fever with pains in the tibia, the so-called "shin fever" of the Germans. Dr. Wm. Godby, of Melbourne, has done much to elucidate these fevers.

Trench Nephritis.—A definite nephritis, with mild uræmia and œdema of the subcutaneous tissues of the body. Its cause has not yet been determined.

It seems to be an infectious disease. It is treated along the set methods and the cases do well.

Fibrositis.—This is an exaggerated and more serious form of the ordinary fibrositis, or muscular rheumatism, of civil practice. I have seen almost every aponeurosis and superficial fibrous band in the body tender and painful. It is a most distressing and disabling condition, and very resistant to treatment.

Shell Shock is another "scrap heap," where all the so-called functional diseases of the nervous system are put. Everyone in battle is the conscious and unconscious receiver of assaults to his nervous system. These enter mainly through the senses of sight and hearing; the shriek of shells, the noise and din of battle provide the stimuli. The central nervous system is more impressionable, by reason of fatigue and alertness. Thus are found all manner of derangements. Loss of speech, loss of hearing, of memory, of power and of sensation. Suggestion under hypnosis and light chloroform anæsthesia have their place of usefulness in the treatment of "shell shock"; but often much more is required to repair the wounded nervous system.

Warmed ether vapour has taken the place of the ordinary ether given by the open method. It has decreased the cost of anæsthesia and the number of cases of bronchitis. Ether vapour is forced by a Junker inhaler through a tube surrounded by a *Thermos* flask, from which the ether vapour extracts heat.

In the foregoing I have attempted to survey briefly the advances during this war of some medical and surgical matters, and at the same time to sum up the recognized treatment, as well as to define matters about which much has been written which, to those who are not on the spot, is obscure and bewildering.

The numerous contributions to the medical and surgical journals can be referred to for detailed and minute accounts of any subject I have spoken of.

PROSTATECTOMY UNDER "LOCAL ANÆSTHESIA WITH NARCOSIS."

By **W. R. Groves, M.D.,**
Honorary Surgeon, Kyneton District Hospital.

That almost any operation is practicable under local anæsthesia is now well recognized, and prostatectomy is frequently performed in this way. Yet it is probably not sufficiently well known that this method of performing suprapubic prostatectomy presents no great difficulties. In the desire to aid in popularizing a method which, on occasions at any rate, is invaluable, I venture to give my experience of it in five cases. It is particularly valuable

(1) when a general anæsthetic is an undue risk to the patient;
(2) when the patient refuses or defers an operation which gives such good results, rather than take a general anæsthetic; and
(3) when an anæsthetist is not at hand.

It might well claim consideration, however, from its advantages to the patient in that he is less shocked and his experience is in every way far happier than when subjected to a general anæsthetic. He goes to sleep before the operation, and awakens a few hours after its completion, surprised to find it over and feeling and looking as though nothing had happened. I have not experienced any disadvantage to the patient; but to the surgeon, at any rate to one who has limited opportunity for practice, it means the expenditure of a little more time and patience.

Of the five cases two were in old men, aged 79 and 81. The latter was just one of those cases where the method proves invaluable. A delicate, feeble subject, at any rate firmly believed to be so by himself and his relatives, he developed retention, and had to be catheterized regularly for ten days. For the above reason my advice from day to day that he should be operated upon was not entertained for a moment. When it was finally obvious to everyone that he must be operated upon or die, consent was obtained; and by this time I had the gravest doubts as to his chances of recovery. The other old man was a better subject, but had been catheterized for some days. In both suprapubic cystotomy was performed, and drainage established for some days, the prostate being removed after the renal functions and general condition had improved. Cystotomy is a simple procedure under local anæsthesia alone, but the presence subsequently of an infected wound surface certainly complicates the later prostatectomy, as the infiltration is undertaken through an infected surface. In the first case this resulted in infection of the surroundings of the wound and consequent delay in healing. In the second case it was practically obviated by avoiding injections through the granulating surfaces and by introducing the needle through sound skin only at spots touched with pure carbolic. This is a practical point of value in such cases.

The other three cases were good subjects, the prostatectomy being primary, after only one or two catheterizations. In these cases the wounds ran a normal course. In all cases the anæsthesia was perfectly satisfactory but for some spasm and rigidity in two of the younger subjects who were not so completely narcotized. This occurred during the enucleation of the prostate, and made manipulation difficult. In one of these a few drops of ether on a mask quickly overcame the difficulty. In the other the operation was completed in spite of it for the purpose of demonstrating that no general anæsthetic was necessary, and this patient remembered no more of the operation than the others. The other three patients slept soundly, in fact snored, and remained quite relaxed throughout the operation. All the patients stated subsequently that they experienced no pain, everything being a blank practically from the time of the first injection of narcotic. One stated that he remembered "hearing the doctors talking, but nothing of what was said." On awakening some hours after the operation they were surprised to learn that the operation was over, and the absence of shock and discomfort was striking. Another feature was the small amount of blood lost

during the operation, but later on in all cases there was some rather sharp oozing when the effect of the adrenalin wore off. However, I am certain that the amount of blood lost was less than is usually encountered on the table during enucleation under general anæsthesia.

In each case the method of procedure was as follows:—

1. Veronal gm. 0.5 (gr. vii. ss.) the night before the operation.

2. One hour before the operation a hypodermic injection of morphine, gm. 0.015 (gr. ¼), and hyoscine gm. 0.0006 (gr. $^1/_{100}$) was given. The eyes were bandaged and the ears plugged, and the patient kept quiet and assured that he was going to sleep. Just before the patient was carried to the theatre hyoscine gm. 0.0006 (gr. $^1/_{100}$) alone was given.

3. Half an hour before operation 0.6 to 0.9 gramme (10-15 grains) of orthoform in a suppository was inserted into the rectum to render that region less sensitive to the digital manipulations.

The local anæsthetic used was novocain in 0.25% and 0.5% solutions.

Novocain 0.25 gm. (gr. iv.)
Sod. chlor. 0.44 gm. (gr. vii.) } = 0.25% solutn.
Aqua. 100 c.cm. (℥ iii ss)

This was prepared and sterilized for 20 minutes in a water bath, and when cold 0.5 c.cm. of adrenalin from an ampoule added. I found half this quantity (50 c.cm.) ample for the cystotomy portion of the operation. The stronger 0.5% solution, with adrenalin 1 c.cm. added to the 100 c.cm., was used for infiltrating the prostatic region.

With a fairly large incision in the bladder wall, efficient retraction, and a good light, one can infiltrate the prostatic region, well pushed up by the finger in the rectum under the guidance of the eye. It is very noticeable how the swollen glandular structure becomes pale and shrinks under the influence of the adrenalin. However, I have found it quite practicable with the usual sized incision to infiltrate under the guidance of the finger alone, using a record syringe and a long needle of 3-4 inches. These long needles are apt to break with any leverage, which is difficult to avoid. Therefore a syringe fitted with a slightly curved shank 3-4 inches long, to which a short needle can be fitted, would be a distinct advantage. In infiltrating around the prostate an endeavour is made to pass the needle just deep enough to infiltrate beneath the mucous membrane and into the capsule of the gland, and to avoid injections into the gland itself as far as possible, where it is only wasted. Plenty of solution is used. Anteriorly, posteriorly and at the sides of the prostate injections are made down towards the apex of the gland, and then the needle is guided into the prostatic urethra and through the mucous membrane on either side to infiltrate this region.

It is only fair to draw attention to the important rôle played by the narcotic in these cases. No doubt in much of the work described as being done under local anæsthesia the same applies, and the fact that the analgesia is supplemented by narcosis deserves more emphasis. My experience of the use of morphine and hyoscine in obstetrics as well as surgery makes me wonder how much might be done under narcosis alone. Of course from the anoci-association point of view it would be inadvisable to depend too much upon it and not to make thorough use of the local anæsthetic.

I would like this opportunity of drawing attention to one or two practical points which are worth bearing in mind in prostatectomy cases:

1. If the bladder is sutured to the abdominal wall by material which may not be absorbed, it is well to keep a record of the number of sutures introduced and watch that none find their way into the bladder. Some years ago in a case in which I performed prostatectomy symptoms subsequently developed resembling those of vesical calculus, and the bladder had to be reopened. What was my surprise to find a pear-shaped calculus with a piece of silkworm gut projecting at its apex like a stalk?

2. Squier and Deaver advise that the incision in the bladder be made as high up on the fundus as possible, the peritoneal reflection being pushed up if necessary. If the drainage tube is subsequently left in the upper angle of the incision, the resulting sinus will usually heal readily. They point out that a persistent sinus is usually found to lead down towards the base of the bladder.

3. Enucleation, according to Squier, is best begun by passing the finger into the prostatic urethra, breaching the mucous membrane and so-called capsule of the gland in this region anteriorly. The finger has passed out through the encircling fibres of the internal vesical sphincter, and the enucleation is completed underneath, as it were, that is, external to this muscle, which means a minimum of injury to it.

4. Avoid irrigations, and there is less liability to the "urinal like" odour so objectionable and characteristic in some cases, and also to phosphatic deposits on the granulating surface of the wound. I have usually administered a urinary antiseptic, both before and after operation, but in some cases this has been discontinued after a few days, so that apparently neither irrigations nor urinary antiseptics are necessary as a rule.

5. Lastly, I would draw attention to the obvious danger that obtains in the use of the enema or rectal tube in these cases.

A NOTE ON CARBUNCLE.

By **J. Forbes Mackenzie, M.B.,**
Surgeon to Out-Patients, St. Vincent's Hospital, Melbourne.

The general view of the pathology of carbuncle is as follows: it is a boil affecting several neighbouring sweat glands or hair follicles; a localized gangrenous nodule of skin, which may develope as the result of the eruption of a number of furuncles in the same locality; an infiltrating septic process, which commences in the subcutaneous tissue or deeper parts of the true skin.

The carbuncle often continues to spread, even after the pus has found a vent. The reason for this is explained later. The inflammation is generally be-

lieved to begin in the pilo-sebaceous follicles and sudoriparous glands. In other definitions boils and carbuncles are classified together, but a differentiation is made between a boil and a carbuncle by having regard to the fact that a boil has one discharging opening and a carbuncle multiple openings.

The traditional treatment is, and has been, crucial incisions, or straight incisions, or incisions uniting the small openings already in existence, with or without the use of pure carbolic acid. Cutting with scissors and scraping away of the superficial necrosed tissue was a method of treatment, but was abandoned on account of the danger of pyæmia caused by interference with the thrombosed veins. An authoritative article states that a thorough scraping will expose and extend down to the deep fascia.

We have all been trained in views such as these, and have treated our cases accordingly, and have not, I venture to say, been satisfied with the slow progress of the cases under our care. Our incisions and scrapings do not seem to make the carbuncle look any better, and a tendency to spread, even after the incision is made, gives rise to an uneasy feeling that our interference has spread the infective condition.

All this is, to my mind, a definite demonstration that our conception of the pathology of the lesion is faulty; that the natural result of a faulty pathological conception is the birth of a faulty treatment, and that this has occurred.

When we recognize that a carbuncle is something more than a subcutaneous inflammatory lesion, and that it is in reality a sub-fascial lesion, we shall begin to make progress in its treatment. My view is that the pathological condition is a septic thrombosis of vessels, probably caused by the infection from the blood-stream of an area of lowered resistance, an area perhaps having been the site of trauma, chemical, mechanical, or thermal.

Green's "Pathology," in which, by the way, I can find no mention of the word carbuncle, contains the statement that a circumscribed gangrene implies a circumscribed cause. Recognize this lesion as being sub-fascial, circumscribed, and with a circumscribed cause, if it pleases us, and we see a serious difference between a boil and a carbuncle. There is an area of septic necrosed tissue deep to the fascia.

It is admitted that evacuation is the correct treatment; but there is as much chance of evacuating an appendical abscess by incising and scraping the abdominal wall as there is of evacuating the result of the carbuncular inflammation by scraping and incising the surface tissues.

Any incision that is to do good must penetrate to the necrosed focus beneath the fascia. Anything short of this depth will only intensify the sufferings of the patient and add to his danger. The superficial necrotic tissue is only evidence of the deep lesion, just as lava is evidence of a volcano. Make an incision down through the fascia and the patient is almost at once out of pain, and certainly much more out of danger, than after the traditional scrapings and cuttings.

Clean out the necrosed substance and pus, dry out with gauze, but do not be tempted to curette out the cavity opened into. Pour into the cavity enough ether to fill it up, and allow the ether to bubble away; then fill up again with ether and apply dry gauze dressings. Follow up the dry gauze dressings after 24 hours with a dressing of gauze moistened in hypertonic salt solution, with or without the addition of sodium citrate solution, irrigating the wound freely with the same solution.

When the sloughs have all separated and a process of granulation is becoming established, a change may be made to boracic fomentations.

Ionization is mentioned as helping to hasten the clearing-up process, but I have no personal experience of this.

The general treatment depends, of course, on the type of patient, but, as a rule, is stimulating and non-saccharine, and even, in the non-diabetic type, of a no fruit character.

Reports of Cases.

JAUNDICE IN EARLY SYPHILIS.

By G. V. Hickey, M.B., B.S.,
Registrar, St. Vincent's Hospital, Melbourne.

The following case appears to be sufficiently interesting to be worth recording:—

R.K., æt. 17 years, a female, was admitted to St. Vincent's Hospital on November 8, 1916, under the care of Dr. Alex. Lewers. She was sent in from the Out-Patients' Department, which she had been attending for an infection of the vulva, which was regarded as a specific infection. She admitted the possibility of such infection about five weeks previously, and stated that the vulval condition had been present about three weeks.

Seven days prior to admission to hospital she noticed that she was getting yellow, and this rapidly deepened. For two or three days she had also suffered from vomiting, and the vomit contained a good deal of bright blood.

The bowels had been regular. She stated that the periods had been regular. She has noticed a rash on her skin for several days. Her general health was good.

On examination the patient was a well-developed and nourished girl. She was markedly jaundiced, and there was also a rash—erythemato-papular in type—on the extensor surfaces of the limbs. Its precise colour was marked by the deep yellow colour of the skin.

The tongue was clean. The heart and lungs appeared to be normal. The liver was enlarged one finger-breadth below the costal margin. It was markedly tender on palpation, and there was tenderness on palpation in the epigastric mid-line.

The external vulvar surface was inflamed, and presented numerous vesicular lesions like small blisters, a condition also present on the side of the thigh. The inguinal glands were enlarged and tender. The temperature was 98° F., the pulse-rate 70, the respirations 20, and the blood-pressure 120 mm.

Urine.—Dark amber colour, acid, specific gravity 1,040, no albumin, no sugar. Bile was present.

For the ensuing three days she appeared very ill; vomiting was frequent, the vomit containing bright blood. She complained of headache and sore throat, but no ulceration of the throat was visible.

Thereafter for a few days the condition remained about the same. The hæmatemesis persisted, and each time the throat was gargled the fluid returned blood-stained.

On November 17 the bismuth mixture which had been prescribed on admission was stopped, and she was put on

pil. hydrarg. cum cretâ, gr. 1 (0.06 gm.) *ter in die*. A blood culture gave a negative result. No organism could be isolated from the urine. The serum from a papule was examined with negative results. The Wassermann reaction was positive.

On November 24 the jaundice began to clear up. There had been a cessation of the hæmatemesis for three days. The rash was still visible on the arms.

During the last two or three days the temperature rose in the evening to 100° F.; but this was the only rise during the course. The pulse-rate never rose above 85 at any time.

Thenceforward the patient convalesced without further incident, and on December 5 was free from jaundice, and the rash had disappeared.

On December 7 she was discharged to attend as an outpatient.

The question of interest is whether the attack of jaundice in this patient is to be regarded as an accidental coincidence or as a symptom of secondary syphilis.

Hutchinson ("Syphilis," p. 319) writes: "Jaundice is sometimes observed during the early phenomena of syphilis. Its pathology is not well ascertained, but it is probably of the same nature as the attacks of temporary jaundice usually termed catarrhal. It disappears under specific treatment, and possibly without it. It is sometimes attended by tenderness on pressure, and certain facts seem to imply that it may be followed by yellow atrophy."

Keyes ("Syphilis," p. 365) writes: "Jaundice, though very rare, is the most important lesion under this head (abdominal viscera), and the symptoms are those of ordinary catarrhal jaundice."

D'Arcy Power and Murphy ("A System of Syphilis," Vol. III., p. 49) write: "Apart from the form which occurs in the tertiary stage, due to gummata, jaundice occurs in the secondary stage. It is a somewhat rare complication, being present, according to Werner, in 57 out of 15,779 cases of syphilis, *i.e.*, 0.37%. It is more frequent in women. Gubler, in 1853, first proved the condition to be syphilitic. . . . . It occurs suddenly, and often simultaneously with the rash, which, in these cases, is pronounced. It is seen between the fifth and sixth week after infection."

I am indebted to Dr. Lewers for permission to publish the record of this case, and for his kind assistance in compiling the notes.

Reviews.

TALES FROM ANZAC.

War books of all sorts have been available for many, many months, and those reading at home have had an opportunity of constructing a picture of the various phases of the war; often, indeed, of forming an entirely erroneous conception of the scenes and march of events. The real history of the war, even of a single phase of it, cannot be written yet. The only persons competent to undertake this task are precluded from attempting it during the course of hostilities. Moreover, it must be remembered that war is conducted by two opposing parties, and the account written from one side must of necessity be hemmed in by the limitations of No Man's Land and by the inevitable and natural aspect taken by the one side. Years will pass before a full history of the war can be given to the world. It will probably never be accurate in every particular. There are, however, chapters in the war which have been written and which should be read. A vivid record of the activities of special units may not throw much light on the determination of the issue of one particular part of the campaign, but it can bring it clearly to the mind of the reader what war really means and how those participating in the fighting comport themselves under the altered conditions of life—and death. We owe a debt of gratitude to Colonel J. L. Beeston for having given us in plain, chatty language a description of things as they were in the 4th Field Ambulance of the Australian Imperial Force.[1] He has succeeded in drawing a picture of the events concerning this ambulance during the five months of his stay in Gallipoli. He reveals in his narrative the character of the Australian who has sacrificed everything to fight for his country. Underneath the entertaining sketch and the amusing stories there emerges a psychological picture as strange, as incomprehensible as it is human. The men who faced death lightheartedly and never appeared to take their dangers seriously until a shell or shrapnel or bullet found them, had to struggle at first to overcome a feeling of tenderness, of sentiment, which does credit to their natural inclinations. This drilling of feeling apparently continues subconsciously, in response to the ghastly happenings which fill the day and the night as well. At first, no doubt, the men affect to take more interest in the site of origin of a shell than in its effect on human beings. But it is apparently the nature of things that brings in the train of frequent wounding and killing an intimacy and a familiarity which breeds, if not contempt, at all events a comparative indifference. This artificial mental position enables men, and especially our men, to conduct themselves with a disregard to their own safety and with a display of heroism with which posterity will always associate the word Anzac. Dr. Beeston probably did not intend to illuminate this aspect of the campaign. He has nevertheless done so, and done it with striking ability. His account of the faithful way in which his officers, non-commissioned officers and men conducted themselves and performed their duties must have a good effect on campaigning. It is inconceivable that anyone can read of these deeds, sitting comfortably in an armchair at home, without thinking whether they have any right to that comfort and safety while their countrymen have exposed themselves to such conditions and to such dangers. The psychology of the men on leaving the danger zone is even more puzzling than that referred to. Our author tells of the wild dreams of blissful enjoyment of sheets, a comfortable bed and immunity from shells. And yet, when he first experienced these blessings, he lay tossing, sleepless, on account of the unwonted quiet!

The book fascinates from beginning to end. The life, death and military funeral of his little dog, Paddy, the naïve honesty of Colonel Pope and the recognition of the Turk as a fair fighter and upright opponent are but passing incidents in the book, but they and many others make up a book which we commend to all our readers.

[1] Five Months at Anzac, A Narrative of Personal Experiences of the Officer Commanding the 4th Field Ambulance, Australian Imperial Force, by Joseph Lievesley Beeston, C.M.G., V.D., L.R.C.S.I., Colonel, A.A.M.C., 1917. Sydney: Angus & Robertson, Limited; Crown 8vo., pp. 68.

EPHEMERIS PHARMACOLOGICA.

Messrs. Oppenheimer, Son & Company, Limited, have, through their agents in Australia, distributed copies of their neat practitioners' visiting-book to members of the medical profession throughout the Commonwealth. This annual publication contains much useful information compressed into a small compass. We are informed that the Australian agents, Messrs. Muir & Neil, of 52a Pitt Street, Sydney, will be pleased to forward free of cost a copy of this publication to any medical practitioner who has not received one.

Correction.

In the prescription contained in Dr. H. Seaward Marsh's report of a case of ulcero-membranous stomatitis (see *The Medical Journal of Australia*, February 24, 1917, p. 160) a typographical error has occurred. The prescription should read:

R.

Vin. ipecac.	24.0
Glycerini	6.0
Liq. arsenicalis ad	48.0 (not 30, as printed)

We have been asked to announce to medical practitioners in Sydney and suburbs that, owing to the death of Dr. J. Froude Flashman, it has been decided to close the Wandsworth Pathological Laboratory, 30 Elizabeth Street, Sydney. The work ceased on February 28, 1917.

The Medical Journal of Australia.

SATURDAY, MARCH 10, 1917.

Trust and Distrust.

Rumour, a disreputable jade, has been busy in the large cities of the Commonwealth. She has cast her snares in wily fashion and has sown discontent, distrust and uneasiness at a time when resolves, steadfastness of purpose and conviction were most in place. She has encompassed her listeners with plausible lies, and has persuaded men to disbelieve and to doubt, and has fanned the flame of personal dislike and mistrust.

We have learned of persistent whispers that the attitude which we have adopted in asking medical men to offer their services for duty abroad is mistaken and vain, inasmuch as only those who are in favour in high places, and those whose youth and inexperience form qualifications for posts of importance have any prospect of selection. The cable has been misused to strengthen these erroneous beliefs. Under these circumstances it becomes necessary for us to affirm again that the need for men is real. We have official information on this score, and can assure our readers that the number of men required for the year 1917 will be very difficult to secure. The necessity for urging these facts in every issue of this journal has arisen because the authorities in the Commonwealth desire to enlist the services of many men, and because many of those who would be willing to go labour under the apprehension that the authorities are not meting out proper treatment to them. Much of this is imaginary. All of it is foolish. The fault lies partly on the side of the men who hold back on account of a shadow—a fear that brusqueness and perhaps even some want of tact means something real. Part of the fault may lie on the other side. Those in authority may be unaccustomed to the red tape of officialdom, and may feel the responsibility of their exalted positions. They may hesitate to discuss frankly with their colleagues things of moment to all. They may fail to recognize the necessity of awakening confidence and of gaining the voluntary co-operation of the medical profession as a whole. All this is much to be deprecated. It is unnecessary and to the disadvantage of the country. An effort of both parties is required to remove it.

By looking the facts in the face and by keeping the one all-important fact in mind, a better understanding of the position can be arrived at, and men will find their difficulties vanish. The all-important fact is that it is the duty of each man to bury his personal feelings and to do his duty to his King and country. No other consideration, neither gain, nor safety, nor comfort, may be entertained. The facts of the case may be summarized briefly. No matter how few recruits offer their services for the combatant forces, the task of looking after the sick and wounded Australians is a big one, and will grow bigger within a short time. The authorities in England and France have estimated the number of men needed for this task for the current year. That number may prove too small; it will not prove too large. Certain duties have to be performed close to the firing-line, in trenches, in casualty clearing stations, field ambulances and hospitals, and for these purposes young men, in good physical trim, with a sound knowledge of hospital work, are far better suited than older men whose life of independence has to some extent unfitted them for the work entailed, and whose arteries may be too rigid for the sudden, excessive strain which is inevitably imposed on them in advance positions. The selection is a matter of expediency, and we are confident that no other consideration weighs with the authorities. In the next place, there are positions to be filled at the base hospitals in France and elsewhere. Men of varied experience are required for these posts. General practitioners of several years' standing, hospital surgeons and physicians, specialists and juniors can all be utilized, but it must be understood that they are not all needed at once. Some may be chosen soon; others may be called upon after several months. Thirdly, there are a few specialists for special services in the war zone proper. We venture to express the view that the Australian Imperial Force does not contain provision for a sufficient number of these men, whose services may be of untold value to the

wounded. The qualifications for these posts must be soundness of wind and limb, willingness to subject themselves to discipline, and resourcefulness and adaptability to unfavourable conditions of work. Those who consider that they are fitted for positions of this kind should offer their services, explaining to the Principal Medical Officer of the Military District the nature of the work they are equipped for. It may be that no opportunity will present itself for their services to be accepted; or they may be welcomed and given an important post. This is largely a matter of chance, and under the existing condition of things it must remain so. In the last place, there are those who are willing to take up the work of some men who have been away for two years or more. In regard to this matter, it is necessary to recognize the conditions of service. The exchange can only be effected at the front or in England. It cannot be effected here, but the preliminary arrangements can be undertaken, and the Commonwealth authorities will be glad to facilitate these exchanges. If these conditions are borne in mind, and the spirit of distrust is eliminated from the situation, it may be possble for the medical profession to provide the full number required.

THE FUTURE OF RETURNED SOLDIERS.

It is often said that things are done differently in New South Wales than elsewhere in Australia. This reputation is regarded with pride within the State and at times with dismay elsewhere. At times the most populous State has outdistanced her sisters with ease. Circumstances have occasionally forced themselves on the notice of the other States to the undoubted advantage of New South Wales. It is not our intention to draw comparisons, but rather to recount what New South Wales has done and is doing to fit wounded soldiers for various occupations in life after their return to Australia and their discharge from the Army. Throughout the Commonwealth the State War Councils have supreme control over this work. Each State enjoys considerable latitude in regard to the way in which the task should be performed, and, as usual, New South Wales planned its campaign without heed of what its neighbours were doing. The handling of returned soldiers was entrusted in August, 1915, to the Medical War Committee. As this Committee had no funds at its disposal, and as its reference was regarded as limiting its activities within a narrow range, the offer of the Red Cross Society to take over the provision of the necessary artificial limbs was accepted, and the Committee retired into obscurity for the time being. Then the Repatriation Committee, armed with plenty of money, appeared on the scene. This Committee had a delightful disregard for economy, and was determined to gain the sympathy of the public by a lavish distribution of the funds at its disposal. When a man appealed to this body for advice and assistance, someone had to suggest a trade to which the applicant might apply himself. Whether the selected trade would be suitable or not must remain a matter of opinion. At all events the man was told to apply at some place, such as a garage, where he could serve his apprenticeship, let us say as a motor mechanic. A sum of money was given to the man, to be handed over to the proprietors of the firm from which he was to receive his training. The money was duly passed on, and the term of training was spent somehow—to the advantage of the firm, and possibly of the applicant. In brief, there was no expert control, no attempt at a proper regulation of this most important matter, and, consequently, unlimited waste. After a time the dormant State Medical Committee relieved the Red Cross Society of its duty to provide artificial limbs. The plan of co-opting the services of experts in technical training was given effect to, and the heads of the institutions for the education of the blind, and of the deaf and dumb and the head of the Technical College joined the Committee. The Repatriation Committee awoke to its responsibilities, and, working through a disablement committee began to establish order. The Repatriation Committee entered into a definite arrangement with the Technical College for the purpose of utilizing the available machinery. The Technical College obtained permission to instruct in classes disabled men and also the wives and children of men serving with the Imperial Forces abroad. No fees were to be charged for this instruction. The scheme, which was carried into practice, was for the disabled

man to present himself to the Repatriation Committee and to cause his name and condition to be registered. He was then handed over to the Disablement Committee, whose members assessed the degree of his disablement and noted his previous experience, his bodily condition and his desires in regard to future occupation. A record of the manner in which he was disabled was also registered. A report was then sent on to the Repatriation Committee, with recommendations concerning the training required for the applicant to earn his living at a chosen trade. Up to this time the man remained a soldier, and his discharge was only effected when no further medical treatment was needed to enable him to regain as much as possible of his lost power. The man was then passed on to the Technical College, where his life history, his bodily condition and his mental aptitude were carefully considered, with a view to the wisest selection of a calling. On the basis of this enquiry, a recommendation was sent to the Committee for approval and for a grant of the necessary money. The sanction of the State War Council was obtained at the same time.

Theoretically, this plan should have worked efficiently, and there should have been adequate safeguards against rash conclusions and superficial enquiry into the real conditions. The State Medical War Committee comes into the scheme as a connecting-link between the process of medical treatment and that of commercial training. In practice, however, there are certain defects of a formidable nature. The utilization of the Technical College may create difficulties with the trade unions, and it might become essential to subject these men, even during training, to the rules of the unions. Secondly, the College is limited in respect to room, and to some extent to facilities for a considerable expansion. In order to overcome these difficulties, and also for the purpose of co-ordinating the work of medical treatment with the work of training, a wider scheme has been planned, whereby a training school is to be erected and equipped in connexion with the Randwick General Hospital. The initial cost of this department will be very large, and provision will be made for the handling of many thousands of men. The new orthopædic departments at the hospital will be brought into close connexion with the training school, where the training will be carried out with the object of developing groups of muscles impaired as a result of the wounding or required for the learning of a new occupation, and technical instruction will be accorded as part of the orthopædic treatment. The value of this scheme must depend largely on the personality of those engaged in the carrying out of the details, and to a certain extent on the degree of efficiency with which the selection of the special training is carried out. The prospects appear to be good.

ANKYLOSTOMIASIS.

The extraordinary frequency of the hookworm and its serious significance to the peoples of tropical and sub-tropical lands have caused much anxiety throughout the continent of America and in the majority of the British possessions. Efforts are being made on a large scale to eradicate this worm, especially in districts where it is known to cause directly or indirectly much suffering and death. In Queensland during the fourth quarter of 1916 but 16 cases were notified to the Health Authorities. No other cases have been reported officially in Australia during this period, notwithstanding the probability that the disease is widespread and that it is of importance as a factor disturbing the health of the population. An excellent summary of the means which have been adopted during the past few years to combat this infection has been published in the Tropical Diseases Bulletin,[1] and a promise is given of a running account in future issues of the progress made throughout the world. From the account we learn that in 1909 Mr. John D. Rockefeller endowed a Commission of thirteen physicians, business men and educational experts of the United States with one million dollars for the purpose of endeavouring to eradicate the disease of ankylostomiasis in that country during the following five years. The Commission ascertained that 694,516 persons out of 1,275,850 examined were infected with the worm. These persons were subjected to treatment. Temporary dispensaries were established in order that those persons who could not obtain treatment from local practitioners might find facilities for this purpose, and also to develope the sanitary aspect of the campaign. Unfortunately, the latter function could not be carried out with any real prospect of success, since the dispensaries only remained for one or two months at one site. The results of the five years' campaign were so encouraging that Mr. Rockefeller determined to extend the work. In 1913 the Rockefeller Foundation announced its willingness to assist in the endeavour to cope with ankylostomiasis in any country which might seek its help. In 1914 advantage was taken of this offer by some of the British possessions. The work was carried out under the

[1] *Tropical Diseases Bulletin*, December 15, 1916.

authority and direction of the Government of the colony or country, and the Commission lent its aid by building up permanent health agencies to control the disease. In each case the beginning was modestly small, so that it would be possible for experiments to be made in regard to the methods best suited to the local conditions. As soon as a method was found to work efficiently, it was expanded according to the necessities of the districts involved. The principal methods employed were the dispensary and the "intensive" methods. The former involved the examination of large numbers of persons and the treatment of those found to be infected; the survey of the extent of the infection and a sanitary survey. The latter involved operation within a defined area, the enumeration of the entire population in the area, the examination of the entire population within the area, the treatment of all persons found to be infected, the careful re-examination of every patient under treatment after each weekly course of medicine until a cure was effected, and the co-operation of the Government with the sanitary organization to prevent reinfection by providing against contamination of the soil. During the year 1914 the scheme was introduced in British Guiana, Trinidad, St. Lucia, Grenada, Panama, Costa Rica and Egypt. No less than 37,902 persons were examined. Of this number 21,483, or 56.6% were found to be infected. Treatment was applied in 90.4% of the infected persons, and a cure was effected in 25.6% of those treated. It is probable that the percentage of cures may be higher than the figure quoted, since no returns were available from St. Lucia, Grenada and Panama. In British Guiana the percentage was 79.1, in Trinidad it was 16.5, in Egypt it was 14.9, and in Costa Rica it was as low as 5.3. It has been suggested by Dr. Eric Marshall, of Antigua, that where ankylomostiasis affects a large proportion of the population and causes much sickness, compulsory examination and treatment should be introduced, and suitable latrines should be constructed and maintained. Dr. Angus Macdonald, of Grenada, has pointed out that the drinking of polluted water plays an important part by spreading dysenteric diseases which complicate ankylomostiasis. All observers trace the infection to the soil. The work completed up to 1914 under the auspices of the Rockefeller Foundation is thus of the highest importance from a public health point of view, and its progress will therefore be watched closely by all interested in the problem of keeping the tropics and subtropical countries healthy for both the white man and the native.

THE PROGNOSIS IN DISSEMINATED SCLEROSIS.

The ultimate fate of persons suffering from chronic nervous lesions is usually dismissed in few words in lectures and writings on these affections. This is to a large extent due to the fact that the neurologists do not often have the opportunity of following their patients through a long succession of years. The general practitioner is more fortunately placed in this respect, but he does not often see more than one or two isolated cases of chronic degenerative lesions of the central nervous system in the course of a busy practice, and consequently his limited experience may be misleading, if taken to represent the usual type of case. The medical officer of an institution for aged persons or of a poor-law infirmary in England has more frequent opportunity for studying the course of these chronic diseases through a series of years. In view of the absence of an authoritative account of the result of treatment and of the average course of illness in a considerable series of cases of disseminated sclerosis, the publication by Dr. Byron Bramwell of the results of his investigations into the ultimate histories of 200 patients suffering this disease must be welcomed.[1] He points out that in the great majority of cases death occurs sooner or later, but he also records the fact that spontaneous arrest of a temporary and apparently of a permanent kind may be observed. On full consideration of the improvement which is met with from time to time and in the light of his conception of the pathology of disseminated sclerosis, he has expressed surprise that permanent arrest and cure do not occur more frequently. The patches of sclerosis are in his opinion due to the irritation produced by some form of toxin carried to the nervous tissues by the blood vessels, and distributed through these tissues. He assumes that the toxin is produced within the body, and that the disappearance of signs and symptoms follow on the cessation of production of the toxin, while the recurrence of symptoms is due to a renewal of its production. Theoretically therefore he recognizes the possibility of a permanent cure.

His experience is not very reassuring. He has expended much energy in ascertaining what the later course of disease was in 200 patients seen at various periods in the past. In 106 cases death occurred after periods varying between 7 months from the onset and 37 years. The average duration of life was 10 years and 8 months. In 26.5% the disease lasted 15 years, and in 14.3% it lasted 20 years. He was unable to ascertain the details in 30 cases. Of the remaining 64 patients the disease had progressed in 42, it had remained stationary in 12, it was greatly improved in 7, and 3 patients were quite well. Taking the 170 patients whose fate had been ascertained together, he found that the average duration of the disease was 12 years and 1 month, and that in 8.23% the disease had already lasted for more than 25 years. An acute course with a rapid termination is rare. Arrest for a time is more common, while he gives an account of two patients in whom the disease lasted for 13 and 6 years, and had then remained arrested for 12 years and 14 years. In cases of this kind optic atrophy and Babinski's sign persist, but he regards them as results of changes rather than active manifestations of the disease.

The President, Vice-President and Council of the Royal College of Surgeons of Ireland have intimated that they would be glad to receive information concerning any student, diplomate, licentiate or fellow who may be engaged in help-

[1] *Edinburgh Medical Journal*, January, 1917.

ing the authorities during the present national crisis. We understand that a complete "roll of honour" is in the course of preparation. Information should be sent to the Registrar, Royal College of Surgeons of Ireland, St. Stephen's Green, Dublin, Ireland.

METASTATIC INFECTIONS OF THE EYE.

Dr. E. A. D'Ombrain has called our attention to an error in the report of the proceedings of the meeting of the Ophthalmological Society of New South Wales of February 7, 1917, (see *The Medical Journal of Australia*, March 3, 1917, p. 196). He asked those present if they had noted that meningococcal infections left the affected eye in a worse state on recovery than did metastatic pneumococcal infections. He holds that in the former there appears to be much more plastic exudate than in the latter, and greater subsequent destruction of sight.

It has been announced that Captain J. B. Metcalfe has been awarded the Military Cross for great courage and devotion to duty in handling the stretcher-bearers under his command, and in working continuously under fire for a fortnight.

* * * * *

We are pleased to note that no medical officers are mentioned in the list of Australian soldiers killed in action, died of other causes, wounded or sick, which was issued on March 2, 1917.

Medico-Legal.

A FALSE CERTIFICATE OF DEATH.

On November 20, 1916, Dr. William Lowe, a medical practioner of Heidelberg, Victoria, was charged at the Criminal Court before Mr. Justice Hodges with having made a false statement in a certificate of death. It appears from the evidence that a child, named Mary Elizabeth Hatch, of Diamond Creek, was taken ill in July, 1916, and that Dr. Lowe was called in. A fifth-year medical student, named Bottomley, was sent in Dr. Lowe's place, and, finding the child very ill, probably informed the latter of the fact. The evidence disclosed that Lowe went to the patient's house, but found the child dead. He gave a death certificate in the usual form, to the effect that he had attended the child during her life, and that she had died of pneumonia and shock. Lowe stated that he obtained the information from Bottomley, and that he did not think that he was doing any harm by filling in the certificate. Mr. Justice Hodges directed the jury to find a verdict of guilty on the facts, and intimated that he would state a case for the Full Court to determine whether evil intent must be shown before a conviction could be entered. He did not think that Lowe had been guilty of serious misconduct, and therefore did not require any bail.

On March 1, 1917, Mr. Justice a'Beckett, Mr. Justice Hodges and Mr. Justice Cussen, sitting as the Full Court, delivered a reserved judgement. Mr. Justice a'Beckett said that the facts to which the certificate was given involved no difficulties or obscurities which might lead to misconception. It was clear that the accused knew it to be false when he made the plain statement that he had attended the child, and he held that he had made this false statement wilfully, notwithstanding that he had considered himself justified in making the statement. He therefore thought that the conviction should be affirmed.

Mr. Justice Hodges pointed out that the accused had made the statement that he had seen the child on July 16, 1916, and that she had died on that day. As a matter of fact, he had not attended the child at all. That matter was entirely within his knowledge. The statement on the certificate was therefore false, and intentionally false. There was a tendency to make the case look like one in which there was an effort to cover up a violation of the law, as the certificate of the unqualified person would not be taken, and the difficulty of getting a certificate would lead to enquiry. He held, therefore, that the verdict should stand.

Mr. Justice Cussen pointed out that the accused had admitted that he had made a mistake, but that it was one of expression. The charge was in reference to a wilfully false statement. In order to convict, they ought to be satisfied beyond reasonable doubt that the statement made by the accused was not only untrue, but was wilfully false, because if the jury thought that he had made the statement by mistake it would not come within the statute. He held that the matter should have been left to the jury, and that an honest mistake might be excused in law.

The accused was therefore convicted, and sentenced to be imprisoned until the rising of the Court. The Court rose immediately, and Lowe was accordingly discharged at once.

In passing the sentence, Mr. Justice Hodges made some remarks about being surprised that the British Medical Association had authorized the doing of a wrong. The Secretary of the Victorian Branch of the British Medical Association has published in the daily press a statement denying absolutely that the Branch had authorized "the doing of a wrong," and pointing out that the case of Dr. Lowe had not been dealt with at all by the Victorian Branch. The document which Mr. Justice Hodges stated that he had received was not sent by any official member of the Victorian Branch of the British Medical Association. It is a pity that his Honour allowed himself to be misled by an anonymous communication.

THE HEALTH OF BROKEN HILL.

Dr. J. F. Bartlett, Medical Officer of Health of the Broken Hill Municipality, has issued a report dealing with the fourth quarter of the year 1916, in which he summarizes the conditions obtaining during the whole year. During the quarter there were 231 births registered, which is equivalent to an annual birth-rate of 33 per 1000 of population. In the same period 119 deaths were registered and the death-rate was therefore equivalent to an annual rate of 17. The infantile mortality for the quarter worked out at 134.2 per 1000 births. There were 78 cases of diphtheria notified with three deaths, yielding a case mortality of 3.97%, 26 cases of enteric fever with four deaths, yielding a case mortality of 15.4%, five cases of cerebro-spinal meningitis with three deaths, yielding a case mortality of 60%, and three cases of scarlatina.

During the year 1916 the marriage-rate was 9.46 per 1000 of population and the birth-rate was 33.73. The birth-rate has fallen from 39.81 in 1913 to 37.76 in 1914 and 34.81 in 1915. There were 12 more girls born than boys. The death-rate for the year was 15.42 per 1000. This rate is not very satisfactory in view of the fact that the rates for 1913, 1914, and 1915 were 15.6, 15.75, and 14.56 respectively. More males than females died, the figures being 258 males and 174 females.

The infantile mortality worked out at 96.3 per 1000 births. A marked improvement in this respect has been effected during the past four years, the rate having been 143.38 in 1913. In regard to the cases of infective disease notified we learn that there were 522 of diphtheria as compared with 552, which was the average for the preceding five years. There were 20 deaths from diphtheria. The case mortality was therefore 3.83%. There were 141 cases of enteric fever, compared with 251, which was the average for the preceding three years. The number of deaths from enteric fever was 18 and the case mortality was therefore 12.76%. The total number of cases of cerebro-spinal meningitis was five, and we therefore assume that all these cases occurred in the fourth quarter. There were 41 cases of scarlatina. The incidence was low in 1913, rose in the following year, and reached a high figure in 1915. Tuberculosis is not notifiable in the district, and it is therefore impossible to ascertain a case mortality. There were 19 deaths from pulmonary tuberculosis as compared with 20.6, which was the average for the preceding five years.

The Medical Officer of Health again protests against the deposition of fluid from the cesspits in the centre of the town near the gaol. This matter, he informs us, is now receiving the attention of the Department of Public Health. In a part of the city the old night-soil cart service still obtains. He considers that this practice should be abolished, and that the whole of the service should be uniform. Before the proper disinfection of pans can be carried out a larger supply is needed.

Abstracts from Current Medical Literature.

DERMATOLOGY.

(76) Darier's Disease.

An early case of Darier's disease, represented to be of only one month's duration, is reportel by Max Scheer (*Journ. Cutaneous Dis.*, December, 1916). The history showed that the patient, a female, aged 41 years, had exhibited symptoms suggesting diabetes, viz., dryness of the mouth, excessive thirst, frequency of micturition, together with *pruritus vulvae*. These symptoms had been present for the past two years. Sugar was stated to have been found in the urine. There had also been pain in the left hypochondrium, as well as cardiac palpitation, and occasional flushing. On examination the only physical sign discovered was a soft systolic murmur at the apex. The skin examination disclosed the bends of the elbows, the inner and upper aspect of each thigh, and the femoral regions to be covered with warty papules, for the most part closely aggregated. These aggregations produced to the touch nutmeg-grater-like patches, which were dry even in the femoral regions. The individual papules, although mainly pinhead-sized, attained in the femoral regions the size of a split pea. In colour the grouped masses appeared greyish, with a faint lilac tinge, suggestive of *lichen planus*. Pruritus was absent in the bends of the elbows, but there had been severe itching in the groins. At first Darier's disease was not considered in the diagnosis, the cutaneous condition pointing to either *lichen planus*, multiple warts, or *lichen chronicus circumscriptus*. Microscopical examination was made from one of the lesions of the thigh. This showed a marked dyskeratosis, and enormous hyperkeratosis, together with some parakeratosis. Nearly all the transitional stages leading to the formation of the peculiar bodies, *corps ronds*, which are characteristic of the affection, could be made out. A cell would lose its prickles, become swollen, the nucleus would shrink or become fragmented and the remaining cell body appear as a hyaline mass with a condensed, double contoured refractile margin or border.

(77) Keratosis Blennorrhagica.

Marcus Haase records a case of *keratosis blennorrhagica* (*Journ. Cutaneous Dis.*, December, 1916) in a man *aet.* 28 years. The patient had had four attacks of gonorrhœa; the third was complicated with epididymitis; and the fourth with gonorrhœal arthritis. The left knee was first involved, then the right knee and both ankles became affected. About this time an eruption appeared on the left knee resembling water blisters, and was considered to be due to "baking" of the knee. The lesions became crusted, and the eruption spread over the trunk and limbs, the face being unaffected. The urethral discharge then ceased, the arthritic pains improved, and the eruption cleared with the exception of that on the soles of the feet. Whilst the eruption was at its height some of the nails of the fingers and toes were exfoliated. Three months later the patient was able to work, but after an interval of five months of work, signs again appeared in both knees, and the eruption once more became general. The discharge reappeared, following massage of the prostrate gland. The patient had been previously treated at various hospitals, and at this stage came under the observation of the author. He had lost considerably in weight, but was not markedly anæmic. The right knee and both ankles were swollen and painful, and there was a generalized eruption over the body. Some of the lesions were erythemato-squamous, and covered with thick, greasy scales, but the predominating character of the eruption consisted of various sized crusted lesions. The arthritic and cutaneous lesions have shown exacerbations. The temperature has run a course of low grade sepsis, pain has been intense, and the patient's mental condition poor. Cultures from the blood and pustules were negative. Gonococci were absent in sections from the skin and epitrochlear glands, and inoculation of tissue from these parts into various media were likewise negative. The organism was alone found in material expressed from the prostrate gland.

(78) Rontgen Ray Diagnosis of Bronchiectasis.

A. B. Moore discusses the value of X-ray examination in bronchiectasis, and points out, among other things, that a correct diagnosis is arrived at with difficulty, that the condition may be due to the presence of a foreign body, and that it is frequently mistaken for pulmonary tuberculosis (*Amer. Journ. Roentg.*, November, 1916). He discusses the aetiology of bronchiectasis, and classifies the various types in accordance with their X-ray appearances. He regards the three forms, (*i*) infiltrative, (*ii*) cylindrical, (*iii*) sacculated, as representing different stages of the condition. In the infiltrative type the appearance is that of a stringy increase in density along the course of the bronchi radiating outwards from the hilus toward the periphery. In the early stages of the disease this is not well marked, and the radiographic picture does not differ materially from that of a chronic bronchitis. The changes are, however, more localized, and are most marked towards the base of the lung. In the cylindrical type there is a mottled increase in density extending along the course of the bronchi and producing a more or less fan-shaped shadow. The author points out that it is advisable to make the patient cough up as much of the bronchial secretion as possible, and to prepare a second radiogram immediately afterwards. The sacculated type is characterized by the localization of distinct pseudo-cavitation surrounded by dense fibrous tissue. The cavities are almost invariably multiple, and may arrive at the size of a walnut. Thickening of the pleura is as a rule uncommon in bronchiectasis. The condition must be differentiated from chronic purulent bronchitis and from abscess of the lung.

(79) X-rays in Diabetes.

J. T. Case (*Journ. Amer. Med. Assoc.*, September 16, 1916) describes the results of his investigation of the röntgenological appearances of the alimentary tract in diabetes in a series of 72 cases. In many cases gall-stones were found, and the author has come to the conclusion that the frequency of their presence in diabetes is increased as compared with non-diabetic persons. In a large number of his patients the stomach was found to lie in an unusually transverse position. This was probably due to adhesions, and possibly to obesity as well. The time occupied by the emptying of the stomach was found to be accelerated. The duodenum also passed on its contents more rapidly than usual. In only one case was definite duodenal stasis discovered. He failed to bring the ampulla of Vater into view in any of these cases. While duodenal stasis could not be demonstrated, ileac stasis was discovered in several cases. Incompetence of the ileo-cæcal valve was discovered in some cases, and spasticity of the distal portion of the colon proved to be common. Case comments on the unexpected infrequency of duodenal stasis in view of the general assumption that this condition is frequent in diabetes.

(80) Radiographic Control of Pneumothorax.

In dealing with the radiographic control of artificial pneumothorax induced for the treatment of pulmonary tuberculosis, I. S. Hirsch lays stress on the necessity of applying the method continuously (*Med. Record*, June, 1916). He regards the control as essential for the proper selection of cases in which pneumothorax should be applied, for the determination of the degree of collapse, and for ascertaining the effect of the procedure on the opposite lung. X-rays enable the observer to ascertain the degree of pneumothorax, and to discover whether it extends to all parts of the pleural cavity or is confined to one particular portion. By its means the condition of the lung can be watched, more especially in regard to the amount of the organ collapsed. It is possible by these means to ascertain the presence of effusion and the condition of the pleura, as well as the position and condition of the heart and mediastinal contents. If the heart is displaced the degree of strain imposed on the vessels can be estimated. In the

last place, the radiographic control yields information concerning the excursions of the diaphragm and its position relative to the lungs. The presence of surgical emphysema can also be detected.

BIOLOGICAL CHEMISTRY.

(81) Antigenic Properties of Nucleo-Proteins.

H. G. Wells has demonstrated that certain β-nucleo-proteins can act as antigen in anaphylactic reactions in guinea-pigs (*Journ. Biol. Chemistry*, December, 1916). The nucleo-proteins of the tissues are no longer regarded as chemical entities but as mixtures of substances, the nature of which depends on the method of preparation. They all contain nucleic acid admixed with proteins. The α-nucleo-proteins are separated by cold extraction with water, salt solutions or weak alkalis, and are precipitated by acetic acid. The β-nucleo-proteins are extracted with boiling water, and are thrown from suspension by acetic acid. The α-nucleo-proteins represent salt-like compounds of nucleic acid with proteins of uncertain and highly variable character, while the β-nucleo-proteins are compounds of guanylic acid with protein. The author has tested the antigenic properties of three carefully purified preparations of β-nucleo-protein. These were separated from ox pancreas, from ox spleen, and from pig pancreas. The sources of the nucleo-protein were selected so that the species specificity and the organ specificity of the proteins might be examined. The substances were separated in such a way as to avoid contamination with other proteins which might interfere with the anaphylactic reactions. Each substance gave the biuret, tryptophane and Millon's tests. Upon hydrolysis they yielded reducing sugar and purine compounds. The guinea-pigs were sensitized with 3 mg. of the proteins to be tested. Three weeks later the guinea-pigs received an intra-peritoneal injection of 50 mg. of protein. Guinea-pigs sensitized with nucleo-protein from beef pancreas reacted on injection with the same protein, with beef serum and with nucleo-proteins from the pig's pancreas and from the ox spleen. Guinea-pigs sensitized with beef serum, reacted with the nucleo-protein from the pancreas of the ox. Analagous results were obtained with the nucleo-proteins from the pancreas of the pig and the spleen of the ox. While reactions take place in all cases, they are most severe with the homologous nucleo-proteins, of moderate intensity with the proteins of the serum of the same species and with the protein of the same organ of another species, and least severe with the nucleo-protein from another organ of the species used to sensitize the guinea-pig. The discovery that the β-nucleo-proteins give rise to strong anaphylactic reactions is of interest, since these substances are prepared with boiling water. Most proteins lose their power to act as antigen upon heating them. Caseinogen, ovomucoid and the proteoses of vegetable tissues are the only proteins known to yield active anaphylactic reactions after the protein has been heated to the boiling point. The α-nucleo-proteins lose their power to act as antigen during purification by repeated precipitation and solution in the cold. The protein united to the nucleic acid, is thus different from that in the β-nucleo-protein. The protein in the β-nucleo-protein is probably not coagulable by heat, as is also the case with caseinogen. It is also probably a complete molecule, since the cleavage products of proteins do not give rise to active anaphylactic reactions. The crossed reactions between the three preparations indicate the co-existence of common antigenic groupings, or the presence of a trace of serum proteins not separated during the process of purification of the nucleo-protein. While some relation is evident between these proteins, it appears probable that these substances are not identical from the chemical point of view.

(82) Scorbutus.

H. B. Lewis and W. G. Karr have examined the blood and tissues of guinea-pigs fed upon an exclusive diet of oats (*Journ. Biol. Chemistry*, December, 1916). The animals exhibit a disease regarded as scurvy after being fed upon oats for a comparatively short interval of time. The shortest period in which that disease is manifested is 15 days, the longest period 30 days, and the average period 22 days. The animals were allowed an unlimited amount of food. They were weighed each second day until their weight commenced to diminish, and then daily. The animals could be kept in perfect health by allowing them cabbage or orange juice, or pulp. The addition of 15 gm. of cabbage to the daily ration maintains the normal weight of the animal, and prevents the occurrence of hæmorrhages. Ten grammes of orange pulp or 5 c.cm. orange juice had the same effect. The addition of various amounts of sodium citrate to the diet had no influence in preventing the onset of the symptoms of malnutrition. Samples of blood were withdrawn from the guinea-pigs while they were in good health and during the progress of the disease. The amount of urea, present in the blood, was estimated. The concentration of urea in the blood was found to increase several times with the onset and progress of the scorbutus. The animals, which did not develope scurvy owing to the use of cabbage or orange, did not show any augmentation of the quantity of urea in the blood. Starvation does not cause any increase in the amount of urea in the blood. As the guinea-pigs refused to eat, it had been suggested that the increased quantity of urea in the blood was due to lessened elimination by the kidney in consequence of a diminished in-take of water. When large amounts of water were given forcibly to the guinea-pigs in which the disease had developed, the concentration of urea in the blood was still twice that in healthy animals.

(83) Hæmic Concentrations of Water and Glucose.

A. Hiller and H. O. Mosenthal have estimated the quantities of water and of glucose in the blood with the idea of determining whether any relationship exists between the concentrations of these substances (*Journ. Biol. Chemistry*, December, 1916). They have employed micro-methods of estimation, and have made a series of estimations on the blood of different individuals at intervals of 10 or 15 minutes. The subjects of the observations have been healthy individuals, who have served as controls, persons to whom known amounts of glucose have been administered and patients suffering from diabetes mellitus. They find that in healthy normal individuals there are two types of results in regard to the concentration of glucose. The amount of glucose in the blood may remain constant in a series of determinations, or the amount of glucose in the blood may steadily diminish. The concentration of water in the blood varies widely in the same individual within a few minutes. Changes amounting to 1 per cent. in the quantity of water were frequently noted between successive determinations. It was not possible to discover any relation between the amount of glucose and the amount of water. With the quantity of glucose in the blood rising or falling the amount of water varied in an irregular manner. The percentage of water in the blood of healthy persons might be higher or lower than in the blood of patients suffering from diabetes in whom the amount of sugar in the blood was several times that in the normal person. The amount of water in the blood appeared to bear no relation to the amount of polyuria exhibited by the diabetic patient.

(84) Lipoids in Blood.

E. F. Terroine (*Journ. de Physiol. et Path. Générale*, January, 1916) has estimated the amounts of cholesterin, fatty acids and total lipoids in the blood of different species of animals and in different animals of the same species. A considerable range of variation in the quantity of total lipoids is found in the blood of different animals of the same species. This range is about 50% on a figure of 4.5 parts per mille. In the same animal at different times the figure is so constant that the author proposes a "lipæmic index" for each animal. The ratio of the quantity of cholesterin to the amount of fatty acids behaves in a similar way. The author proposes the term "lipæmic co-efficient" for this ratio in each animal. In further contributions the author will deal with the changes in the index and co-efficient produced by altered physiological states and by pathological conditions.

British Medical Association News.

MEDICO-POLITICAL.

At a general meeting of the Queensland Branch, held on February 2, 1917, Dr. John Lockhart Gibson, of Brisbane, was elected a member of the Australasian Medical Publishing Company, Limited, in the place of Dr. Wilton Wood Russell Love.

At a special meeting of the Council of the New South Wales Branch, held on February 27, 1917, for the purpose of instructing the delegates of the Branch concerning various matters which will be considered by the Federal Committee at its next meeting, the following proposals were adopted:—

That with the objects (1) of establishing equality of obligation among medical practitioners in Australia to undertake military service for the purpose of the war, and (2) of maintaining the Australian Army Medical Corps in such a state of efficiency as will enable it to meet the requirements of the Army, due regard being had, at the same time, to the needs of the civil population for medical attendance, it be a recommendation:—

(*a*) That steps be taken to introduce compulsory enrolment of all medical practitioners registered as legally qualified medical practitioners, or entitled to be so registered in any State, as persons liable for enlistment and service as officers in the Australian Army Medical Corps, and

(*b*) That a Medical War Committee be constituted for each Military District in the manner indicated in the Memorandum of the Director-General, Australian Army Medical Service of 2nd October, 1916, to make selection for and recommendations for exemption from Australian Army Medical Corps Service of the persons so enrolled, and to have such other functions and powers as will enable it to undertake the organization of the medical profession in the district in relation to the needs of the Australian Army Medical Corps and of the civil population.

It was further determined that a copy of these resolutions be sent to each Branch of the British Medical Association in Australia with a request that the members consider the propositions and instruct their delegates in regard to the attitude they should adopt at the meeting of the Federal Committee.

The following letter has been addressed to the Secretaries of the Branches, accompanying the resolutions:—

Equality of Obligation to Serve.

Dear Sir,—In New South Wales, and, it is understood, also in other States, since the revocation (22/11/16) of the Proclamation of 29/9/16 introducing Compulsory Military Service, opinion has been widely and strongly expressed (see *The Medical Journal of Australia*, 1916, Vol. II., p. 433, *et passim*) that all medical practitioners should hold a commission in the A.A.M.C. Reserve; and much effort has already been spent in attaining this desirable object. In New South Wales a proposal to this effect has, in fact, been considered at meetings of several of the Local Associations of Members, both in the metropolitan area and in the country, and in every instance has met with unqualified approval. In the circumstances it is reasonable to assume that the members of the Association wheresoever residing in Australia will welcome it.

It will be apparent to everyone that the fairest and most direct procedure would be the establishment, by law, of equality of obligation to serve, imposed on all medical men as members of a class, subject to their liability for service being regulated by a properly constituted tribunal.

If this class, as represented by the British Medical Association, will voluntarily approach the Government with a view to such procedure being introduced, it might reasonably be expected that means might be found under the Defence Act and the War Precautions Act for bringing it about.

Under a quasi-compulsory system, such as that suggested, the difficulties which stand in the way of an effective individual voluntary enlistment, extending throughout the class, would be non-existent; and the organization of the profession with due regard to the needs of the service and the requirements of the civil population would be comparatively easy of accomplishment.

I enclose herewith a proposal, marked "A" (to be converted into a recommendation to the Minister for Defence), for the enrolment of the profession as preliminary to enlistment and for the regulation of such enlistment by Medical War Committees. It has been approved by the Council of the New South Wales Branch with a view to its submission to a general meeting of the Branch and to the Federal Committee of the British Medical Association in Australia.

May I suggest that this proposal be considered by the Council of your Branch with a view (if necessary, after consideration by your Branch as a whole) to the representatives of your Branch on the Federal Committee being instructed in regard to it.

Faithfully yours,

(Signed) R. H. TODD,

Honorary Secretary, New South Wales Branch.

March 3, 1917.

This matter, together with other matters dealt with by the Council, will be submitted to the annual meeting of members of the New South Wales Branch, to be held on March 30, 1917.

A meeting of the Council of the Victorian Branch was held at the Medical Society Hall, East Melbourne, on February 28, 1917, Professor R. J. A. Berry, the President, in the chair.

The report of the Organization Committee dealing with the question of reopening negotiations with the Association of Friendly Societies in Victoria was discussed. The Committee submitted in its report "that it be a recommendation to the Council that negotiations with the Friendly Societies which were interrupted in August, 1914. be reopened." The report was adopted by a unanimous vote. The Secretary was instructed to approach the Secretary of the Association of Friendly Societies with a view to convening a meeting of the conference of ten for the purpose of resuming negotiations.

It was decided to invite the Federal Committee to adopt a scheme whereby there might be uniformity in the practice of sending notices to and in the payment of subscriptions by members transferred from one Branch to another.

The Council considered a communication from the Pharmacy Board dealing with the question of the indiscriminate selling of headache powders containing "potent drugs" such as acetanilide, etc. The Council, while sympathising with the Board that the sale of these drugs should be restricted, expressed the opinion that "potent drugs" should be sold only on the prescription of a legally qualified medical practitioner.

The Council also considered a memorandum from the Pharmacy Board dealing with cypher prescriptions. This matter was referred to the Ethical Committee for consideration and report.

It was reported that enquiries have been made on repeated occasions as to whether the *Medical Act Amendment Act* of 1916 had come into operation. The reply which had been given to enquirers was that the Act had received assent on December 22, 1916, and was therefore in force, but that it was doubtful whether any action would be taken for an infringement of the clause until the *Venereal Diseases Act* had come into force. In regard to whether a medical officer of a lodge would be compelled to sign in full each prescription in the patient's lodge book, the Secretary had received the following letter from the Public Health Department, dated February 23, 1917:—

Adverting to your telephone communication re signing of prescriptions, I beg to state that I have discussed the matter with the responsible authorities, and have to inform you that the law allows no discretion in the matter; therefore the provisions of the *Medical Act*, 1916, No. 2870, must be carried out. This act provides that:—

Every written prescription of a legally qualified medical practitioner shall be dated and bear the

address and usual signature (including the surname) of each practitioner.

This Act is administered by the Medical Board, which is a branch of the Chief Secretary's Department.

The Health Department is concerned only with signing, etc., prescriptions for venereal diseases. It is not proposed to take any action in this matter under the Venereal Diseases Act until the regulations are gazetted, but it must be clearly understood that in the meantime practitioners are responsible under the *Medical Act*. (Signed) E. Robertson, Permanent Head.

The action of the Secretary in this connexion was approved.

The Secretary was instructed to address a letter of sympathy to the widow of the late Dr. A. E. B. Forster.

The Secretary was instructed to obtain from the Deputy Federal Commissioner of Taxation a list of exemptions allowed to medical practitioners.

It was arranged that the business for the next meeting should be the consideration of proposed amendments of the rules of the Branch and clinical communications. The meeting will be held at St. Vincent's Hospital. The first part of the meeting will be regarded as a special meeting, and the clinical meeting will take place immediately after its termination. An invitation from General Fetherston to the Branch to hold a clinical meeting at Langwarrin in April was accepted.

The following were elected members of the Branch:—

Dr. Joseph Carroll D'Amer Drew, Fairfield Infectious Diseases Hospital.

Dr. Bernard Denton Fethers, No. 11 Australian General Hospital, Caulfield.

The following gentleman has been nominated for election as a member of the New South Wales Branch:—

Roy Baldwin Minnett, M.B., 1915, Univ. Sydney, Royal Prince Alfred Hospital, Sydney.

Medical Matters in Parliament.

VICTORIA.

In the Legislative Assembly on August 23, 1916, Mr. McLeod, Minister of Health, moved for leave to introduce a Bill relating to venereal diseases and to amend Part V. of the Police Offences Act, 1915. The motion was agreed to. The Bill was then brought in and read a first time.

When he moved the second reading of the Bill on September 14, 1916, Mr. McLeod pointed out the various diseases which were to be regarded as venereal, and enumerated the evil consequences of the failure to treat them effectively. He stated that there were great difficulties in obtaining any accurate figures on the prevalence of such diseases. Even those countries which professed to keep statistics admitted that their figures were unreliable, because many cases were not recorded. It was only in special cases that figures of any value could be obtained. The army authorities had informed the Royal Commission appointed by the Imperial Government that in 1912 there were 13,679 men more or less affected by venereal disease in a standing army of 212,569 men. The naval authorities stated that the strength of the navy was 119,540, and that 12,667 men were afflicted with venereal disease during the year 1912. The Federal Committee concerning causes of death and invalidity were told in evidence that, during 1914, there were 3,326 deaths from inherited syphilis among young children in Australia. Professor Sir Harry Allen had noted 66 cases of undoubted syphilis during 200 post-mortem examinations, while the appearances were suggestive of syphilis in 49 additional cases. The Minister indicated the measures proposed in the Bill to deal with these diseases. Much misery was caused by the lack of immediate and skilful treatment. It was laid down that sufferers from these diseases should report themselves immediately to qualified medical men. The patient need not attend a medical man in private practice. He might go to a clinic. Power was given in the Bill to institute clinics, and some of these clinics would be held at night for those who could not attend during the day. Free treatment would also be provided at all hospitals subsidized by the State. Venereal wards would not be established in the hospitals, but patients would be treated in the ordinary way by the staff, and the Government would arrange to contribute to the cost. It was made an offence, to which a heavy penalty was attached, for any unqualified person to treat these diseases. A person suffering from venereal disease must, under a penalty for disobedience, report himself for treatment. In regard to notification, there was no necessity to expose the person's name and address. Each medical man would be supplied with a book of numbers, and he would report his cases to the Inspector of the Board of Health as numbers. Cards warning against the danger of the disease, notifying the penalty for infecting others and setting out the time when attendance for further treatment would be necessary would be given to each sufferer. If the patient did not attend for this treatment he would be informed that he was neglecting treatment, and that, if he did not obtain it, he would be reported. If the patient still failed to carry out the instructions the Medical Inspector would be given the name and address. The Medical Inspector would tell the patient that, unless the instructions were carried out, arrest would follow. The Chief Inspector was given power, under proper conditions, to arrest the patient and to keep the patient in detention until a certificate of cleanliness could be granted. Right of appeal to a magistrate or judge was permitted. Evidence would be heard in private. A medical board would examine the patient from time to time, to control the period of detention. Women would be entitled to be examined by female medical practitioners if they desired it. Power was taken under the Bill to detain persons arrested for various offences and imprisoned for short periods, when they were found suffering from venereal diseases. Such persons would be held in custody until they were cured, no matter what their sentence might be. The same rule would apply to those in reformatories. Provision was made to enforce secrecy. All inquiries before a judge or magistrate would be in private, and all witnesses would be sworn to secrecy. A clause had been introduced to protect any medical man, who might give a *bona fide* certificate that a patient was suffering from venereal disease, from any consequences arising from the certificate. A heavy penalty was provided in regard to any person suffering from a venereal disease who communicated it knowingly to anyone else. The clause in the West Australian Act giving power to bring any person under examination when the authorities were informed in writing that such person was suffering from venereal disease, had been omitted from the Bill. Opportunity had been taken to increase the penalties of certain clauses of the Police Offences Act, 1915, dealing with obscene and indecent publications. The preliminary warning of certain offenders distributing such literature, was made unnecessary. He thought that the Bill was one to be discussed freely in committee. He moved the second reading. The debate was then adjourned until September 19, 1916.

On the resumption of the debate Mr. Elmslie said that he would support the second reading in the hope that some amendments would be made in committee. He thought that some consideration might be given to means of preventing venereal infection. The use of such measures had lessened the amount of disease in countries where they had been employed. He considered that some steps should be taken to regulate the charges of medical men, as treatment would be compulsory. If this were not done, he was afraid many would conceal their diseases or would go to quacks for advice. He felt that the clause dealing with the dispensing of prescriptions needed amendment. It appeared to him that, under the clause as drafted, a prescription would require the endorsement of the doctor each time that it was presented to the pharmacist. He was of opinion that those in the country, distant from medical men, should be able to obtain certain remedies without consulting a medical practitioner. He thought that a standardized remedy might be available for some venereal complaints.

Mr. Farthing was anxious that the clause prohibiting the supply of a drug for the treatment of venereal disease should be modified, so that there should be no danger that a pharmacist who sold such a drug for a legitimate purpose, should be liable to the penalty under the section. He hoped that the chemist would be allowed to sell any drug

or recognized patent medicine, provided he did not sell it for the treatment of venereal disease. He also wished to see Federal action taken with regard to venereal diseases. If this were done, there would be uniformity in action throughout Australia.

Mr. Hannah supported the request for a modification of the clause dealing with the sale of drugs.

The second reading was carried, and the House sat in committee.

Clause 1, dealing with the title, construction and citation was agreed to.

Clause 2, defining a child, venereal diseases, medical inspector, etc., was agreed to after a brief discussion as to the age-limit for a child.

Clause 3, which stated that certain provisions relating to infectious diseases should not apply to venereal diseases, was agreed to.

When Clause 4, giving the Governor-in-Council power to proclaim any hospital as a place of detention under the Act, had been agreed to, progress was reported.

On September 21, 1916, the House again went into committee. Clause 5 was debated at considerable length. The clause read as follows:—

> 5. (1) No person other than a medical practitioner or a person acting under the direct instructions of a medical practitioner shall attend upon or prescribe for or supply any drug to any person suffering from any venereal disease for the purpose of curing alleviating or treating such disease.
>
> (2) Any person guilty of a contravention of this section shall be liable to a penalty of not more than fifty pounds or to imprisonment with or without hard labour for a term of not more than six months.
>
> (3) This section shall not apply to a registered pharmaceutical chemist who dispenses to the patient of a medical practitioner the prescription of such practitioner.

The Minister of Health stated that, in order to prevent blackmail, he would later in committee introduce a new clause that no prosecutions could be undertaken except with the authority of the Minister or somebody under his control. He then moved to add the words "or medicine" after the word "drug" in subsection (1). After brief discussion this amendment was agreed to.

The Minister of Health then moved to insert after "such practitioner" in subsection (3) the words:

> if such prescription is dated and bears the address and usual signature (including the surname) of such practitioner, or who sells or supplies any drug or medicine (except such drugs and medicines as are specified by regulations under this part of this Act) in the ordinary course of his business, provided that such drug or medicine is not prescribed by such chemist for any person suffering from any venereal disease for the purpose of curing, alleviating or treating such disease.

He said that he had consulted members of the Pharmaceutical Society, and they were satisfied with the amendment. He would re-commit the clause if members wished to discuss this matter further. A list would be prepared of the drugs which should not be sold by chemists. He wished to make it clear that, unless a chemist prescribed a drug or medicine, they would be free from any penalty. The chemist must not knowingly supply the drug "for the purpose of curing, alleviating or treating such disease." If the chemist sold the drug to a person suffering from venereal disease he would not be liable if he did not know that the person had venereal disease.

Mr. J. W. Billson did not think that the amendment was clear. He thought that chemists who sold medicines without any knowledge of the purpose for which they were used should not be liable to a penalty.

Mr. McLachlan said that chemists in the country districts had opposed this clause. The amendment had received the approval of the chairman and the registrar of the Pharmaceutical Society. As the amendment safeguarded the interests of the pharmacists he would support it. He thought that the chemists would observe the law as laid down in the amendment.

Mr. Prendergast was doubtful whether the amendment was placed in the correct section. He would have preferred it in sub-section (1). He hoped that a list of drugs which might be sold by chemists without question would be prepared and published.

Mr. Cotter supported the proposal to issue a list of drugs that might be sold by the chemist without question of liability.

Mr. Elmslie asked how medicines would be issued to hospital patients. It was not the custom to sign and date prescriptions in hospitals, as required by the amendment. He trusted that no regulations would be made that would make it difficult for persons to obtain treatment for venereal disease.

Mr. Menzies raised the question of the use of a prescription by a person to whom it had not been given.

The Minister of Health pointed out that the use of such a prescription would be a serious offence.

The amendment was adopted, and the clause, as amended, was agreed to.

Clause 6, setting forth the duty of a person suffering or suspecting that he is suffering from venereal disease to place himself under treatment, was agreed to.

Clauses 8, 9 and 10, dealing with the liability of a medical practitioner to notify cases and to warn the patient, were agreed to.

Some discussion occurred upon Clause 11, dealing with the issue of a certificate when patients were free from infection.

Mr. Elmslie was opposed to granting these certificates. He had been informed that it was impossible to determine when syphilis was no longer infective. He did not think it advisable to give women certificates that they were not liable to convey the infection.

The Minister said some kind of certificate was necessary to determine when treatment should cease. Persons did not continue to be infective, though they might not be cured.

Mr. Webber dealt with the question of the cure of syphilis. He did not consider it advisable to leave the question of the liability of communicating the disease to be determined by medical men. It would be wiser to prohibit the issue of certificates until the medical profession had provided an absolute cure for syphilis.

The clause was agreed to.

Clause 12, on the duty of parents and guardians to compel or induce persons under sixteen years of age to be treated by a medical practitioner, was agreed to, after some discussion in favour of raising the age-limit to eighteen years.

A long debate occurred on Clause 13, granting power to order persons suspected of suffering from disease and not under treatment, to submit to treatment.

The Minister of Health explained that the Medical Inspector could order any person declared by a medical practioner to be suffering from venereal disease and not receiving treatment, to place himself under the care of a medical practitioner. If the patient did not obey the inspector, the Governor-in-Council could order his detention. A further section provided for the right of appeal to a judge or to a police magistrate.

Mr. Prendergast thought that this was the place to raise the question as to the payment for this compulsory treatment. He hoped that regulations would be prepared limiting the amount of fees to be paid to medical practitioners for treatment.

Mr. Snowball asked who would support the families and dependents of those detained for treatment. They had been told that it took years to eradicate the disease. Although detention would apply to those who refused to obtain treatment, it would also apply to those who neglected to do so. He thought that the shame attached to those suffering from these diseases, would induce many, especially women, to avoid notification. These persons would be affected by this clause.

Mr. Menzies thought that some penalty should attach to a medical man who gave a false report, either wilfully or by neglect.

Mr. Billson thought that the clause was too drastic unless the cost of treatment was regulated.

Mr. Solly said this clause would drive patients to consult medical men. They must either allow sufferers to be treated by quacks or by medical men, who had given years

to the study of these diseases. He thought the clause was drastic, but he believed it to be necessary.

The Minister pointed out, in answer to objections, that free treatment would be provided in hospitals and special clinics for those unable to pay for private medical advice.

The clause was agreed to.

Clause 14, giving power to detain prisoners, and Clause 15, providing that hearings before judges and magistrates be in private, were adopted without discussion.

The Minister of Health undertook to introduce an amendment into Clause 16, which gave the right to a female person to be examined by women medical practitioners. It had been pointed out that, while it would be easy to obtain a woman doctor in Melbourne, much delay would be caused in country districts if it were necessary to obtain the services of two women doctors.

Claude 16 was then agreed to.

Clause 17, directing that a person ceasing to be infective shall continue treatment until cured, and Clause 18, making it an offence to infect knowingly another person with the disease, were agreed to.

Clause 19, setting forward the duty of the managers of any hospital subsidized by the State to provide treatment for persons suffering from venereal diseases and limiting the subsidy in cases of default, was considered.

Mr. Billson thought that the clause provided an ugly means of punishing the managers of a hospital, but not of reforming them. He advocated compulsion to provide the necessary treatment for venereal diseases. By removing the subsidy all classes of sick persons were punished.

Mr. McLeod said that the method proposed offered the only simple means of dealing with the difficulty.

The clause was agreed to.

Clause 20, giving the Minister of Health power to take steps to establish hospitals, to arrange for bacteriological and chemical examinations and to disseminate information, was debated.

Mr. Elmslie thought that this clause did not go far enough. It was necessary to educate people on the matter of venereal diseases. He viewed with grave concern the discovery that so many young women suffered from gonorrhœa. He did not think it advisable that instruction should be given in schools on these matters; but he did think that parents should be invited to give information to their children on the dangers of promiscuous intercourse. He trusted that a sympathetic administration would institute a campaign of instruction, since so many authorities believed that education on this subject provided the best remedy for limiting the spread of venereal disorders.

Mr. Mackinnon was sorry that no attempt had been made to regulate the time of marriage after an attack of these diseases. He had been told that no person should marry for three years after an attack of syphilis, and for three months after an attack of gonorrhœa.

Other members endorsed the views of the Leader of the Opposition on the importance of educating public opinion on the question of venereal diseases.

The clause was agreed to.

Clause 21, setting forth the subjects upon which the Governor-in-Council could make regulations, was next taken.

The Minister of Health moved the omission of sub-clause (2), reading—

> (2) All such regulations shall be published in the *Government Gazette* and shall be judicially noticed and shall be laid before both Houses of Parliament within fourteen days after the making thereof if Parliament is then sitting, and if Parliament is not then sitting then within fourteen days after the next meeting of Parliament;

and the substitution of the following:—

> (2) All such regulations when made by the Governor-in-Council shall be published in the *Government Gazette*, and when so published shall have the force of law and shall be judicially noticed and shall be laid before both Houses of Parliament within fourteen days after the same shall have been made if Parliament be then sitting, and if not then within ten days after the next meeting of Parliament, and a copy of any proposed regulations shall be posted to each member of Parliament at least fourteen days before such regulations are approved by the Governor-in-Council.

The amendment was agreed to, and the clause as amended was adopted.

Clause 22, stating that Part 2 should be read and construed with Part V. of the Police Offences Act, 1915, was agreed to.

Clause 23, dealing with the penalties for publishing and distributing indecent literature, was agreed to after discussion.

The Minister of Health moved a new clause:—

> Any person authorized either generally or in any particular case by the Minister may prosecute for any offence under this part of the Act or any regulation thereunder.

The clause was agreed to.

The Bill was reported with amendments.

(To be continued.)

Correspondence.

ENTERIC FEVER AND SOIL CONTAMINATION.

Sir,—In replying to my letter of the 24th February issue you say that, unsupported by data, impressions cannot be regarded as scientific argument. The following are some of the impressions which influenced me to challenge the justification for the remarks in the editorial of the 10th February issue. For the sake of brevity they were withheld in my letter of the 24th February issue.

(1) Outbreak of typhoid in the Hospital for Insane, Ararat, Victoria, in 1908, following on the digging up of old underground drains. The outbreak was limited to the patients who lived in the ward where the excavations were taking place. The first patient affected was one who was reported by the attendants as "always poking about where the men were at work."

(2) Outbreak of typhoid at the Hospital for Insane, Kew, Victoria, in 1916, on the male division, when the sewerage was being installed in the hospital ward. The outbreak was limited to the patients in that ward.

(3) Outbreak of typhoid at the Hospital for Insane, Kew, Victoria, in 1916, on the female division, when the cases were limited to patients who came in contact with the affected area. There was no connexion between this and the previous case, as they occurred at different parts of the year. The sewering of Kew is being done piecemeal, on account of shortage of funds available.

(4) Outbreak of typhoid at the Idiot Cottages, Kew, Victoria, in 1916, due to excavations made for building a new mess-room. The Idiot Cottages are quite apart from the adult portion of the Kew Reserve for Mental Buildings, and the outbreak of typhoid occurred at a much later period of the year than the two other cases. In this outbreak the first patients were nurses.

The variability in the times required to kill different strains of the typhoid bacillus was mentioned, because the effect of heat is the most commonly-used test when examing the resistance powers of an organism. You say this has little to do with the problem, although you concede its correctness. Very well then. If we cannot say for certain the exact time that it takes to kill each strain of typhoid bacillus at a temperature of 60° C. (a simple laboratory test), how are we to say how long the organism can live in different soils such as clay, marl, loam, gravel, sand, etc., which are, in the cases I mention, subject to periodical or constant, partial or complete, soakage from the surface or underground drains carrying the effluent from kitchens, sculleries or lavatories?

The investigations mentioned by you, in order to be of any value in settling an argument of this kind, must have included the examination of soils taken from localities similar to those I described as existing in the back premises of thickly-populated institutions, where the majority of the inmates treat all sanitary principles with contempt. Houston, the chief English authority on soil examination, admits that it is an extremely difficult work, as there are so

many side influences. Muir and Ritchie, who are accepted as authorities by most medical schools, says: "It must, however, be noted that such an organism as the typhoid bacillus can exist long enough in soil to be a serious source of danger."

The cases I mentioned were epidemic, and not endemic, and this, apart from other considerations, is against the outbreak being due to a carrier in the institutions.

Both in the 10th February issue and in the reply to my letter in the 24th February issue mention is made of recent investigations proving that typhoid does not live long in the soil, but, beyond that bare statement, no reference has been supplied. It is now incumbent on you to disclose your authorities and the conditions under which they worked, and, until then, perhaps even afterwards, I will adhere to my opinion that "the eminent civil servant" was not unduly apprehensive in taking precautions against an outbreak of typhoid during the disturbances of the soil inseparable from the installing of the sewerage system.

Yours, etc.,

W. A. T. LIND.

18 Walpole Street, Kew,
February 26, 1917.

[We would be glad if others would contribute their views on this important matter. We are therefore deferring our reply to Dr. Lind.]

PROVISION FOR INCAPACITATED MEDICAL PRACTITIONERS.

Sir,—What is to be the position of our profession in the future with regard to its old and infirm or maimed or invalided members? In the past we have been able to put this matter on one side; cases of distress have been rare; when they have occurred they could be dealt with individually; and it is one of our boasts that they have always been dealt with liberally. But there are one or two facts that go to show the likelihood of the position being different in the future.

1. I think that it is almost certain that the result of the war will be the return of certain of our members invalided or in some way handicapped in the pursuit of the profession. This is more likely to happen with younger members who have had no great opportunity of building up practices or of saving. Can we stand by and see them dependent entirely on a pension? Is it fair to wait for individual appeals to be made in the cases of greatest hardship? Are we not in honour bound compelled to endeavour as a profession to establish some fund on a large enough scale to cover these possible cases of hardship in the future?

2. There will, I think, be another class of men returning, with no present incapacity, but in whom the length of time during which they can work at high pressure will be shortened. To that extent their professional lives and their opportunities for laying by for the future will be diminished. Ought there not to be a sort of professional superannuation fund, to which they can contribute for a time, as an insurance for later years?

3. The problem of the old or infirm general practitioner will gradually become an increasingly pressing one. In the past we could ignore it. The less equipped man, physically or mentally, could go to outlying districts; professional competition has not been too keen to make it hard for men to save. But these conditions will gradually change. There has already been a marked change during the last twenty years. Ought we not, if we have the best interests of the profession at heart, to take steps now to secure a fund for the less fully equipped of our colleagues on which they can fall back in their old age?

4. The pause in lodge negotiations during the past two years has led one to think more about these matters. We are rightly seeking to improve the conditions of lodge surgeons. But it seems to me that the ultimate—not immediate—logical outcome of this is the obligation on our part always to provide efficient lodge surgeons. It is not fair to the public for an inefficient man to demand contract work on the same terms as those we rightly ask for the efficient man. The difficulty presents itself in two ways. There is the occasional man who is himself to blame in that he gradually loses his efficiency through alcoholism or some such habit. These cases can probably best be met by the suggestion Dr. Macdonald threw out, *viz.*, that the Medical Board should be given the power to put such men on a "good behaviour test," under penalty of revocation of their registration. But there is another class of men, who, through no fault of their own, as they get older, become blind or deaf or otherwise partially incapacitated. There are numerous instances in the past where such men have voluntarily resigned themselves to the inevitable. But it is not always so, and as the struggle becomes more severe there will be a greater temptation not to do so. I do not know quite how this difficulty is to be met. Either the Medical Board must ultimately have the power to forbid the practice of certain branches of medicine to such men, according to their physical or mental incapacity, or else we must drift along and have such men acting unfairly to the lodges or becoming an ever-increasing army of compulsory blacklegs, forced by their infirmities to take on work at lower terms. Ought we to be content with this outlook? Have we the right to suggest the above-mentioned alternative, unless we have first provided an adequate medical superannuation fund? If such a fund is desirable, is it to be a general one for Australia, or is each State to make provision for its own members? In our own State we have had a Medical Benevolent Fund established for years, which has languished just for lack of vision of possible future needs. An urgent case recently brought before our notice revealed the fact that only the annual revenue—about £20—can be spent in any one year. Either this fund must be re-organized on a larger scale, or a federal movement should be inaugurated to provide for contingencies in the future. It is necessary to recognize the possibility of removals from one State to another. This is the better plan; but there are so many difficulties in the way that one is afraid to suggest it off-hand. What is the position in other States? Would it be possible for some of our business members to put their heads together to provide a common fund? And would not such a movement be a worthy one for us at home to inaugurate just as this juncture? Since beginning this letter I have received a circular from the "Royal Medical Benevolent Fund," in England. The same matter is evidently pressing on the profession in England, even more urgently than upon us. At the beginning of the war we determined that our policy as a profession should be to devote subscriptions to special medical relief funds. Could we not continue this policy by taking up as a profession some movement for an Australian fund, rather than as individuals to send driblets to a fund overseas?

Semaphore, South Australia,
(undated).

Yours, etc.,

FRANK S. HONE.

THE MEDICAL PROFESSION AND THE WAR.

Sir,—Colonel Roth's letter, in the *Journal* (February 24, 1917) is a strong appeal to the profession. At the same time it is somewhat unjust in its assumption that all who have stayed at home are intentional shirkers.

I have particular interest in General Sir N. R. Howse's opinion *re* the unfairness of keeping medical men away from home and practice for more than two years.

May I state my own position? Mine is a "one-man" practice in a large district, my nearest medical neighbours being 23 miles north, 30 miles east, and about 60 miles west and south respectively. Obviously, such a practice is not divisible as is a city one. Any sort of reliable locum tenens is unobtainable, and I have made every effort to get one, and can therefore be sure on this point. I have my wife and four children to consider, and cannot leave my work summarily; while a sale of the practice is impossible under present conditions.

For about a year before the war my assistant was an Army Medical Corps Captain. A month before the war began he purchased part of my practice, and he and I worked in partnership. He volunteered for the Light Horse Ambulance in October, 1914, went through four months in the Gal-

lipoli trenches, has never been off duty from any disability, and is now Acting Lieutenant-Colonel in charge of a Light Horse Hospital in Egypt. In August, 1916, he felt he had done a good share, and suggested a year's exchange with me. I agreed, as I had failed to get a locum, so that I could unconditionally volunteer. He applied to his headquarters in Egypt—presumably to General Howse or his deputy—in October, 1916. I applied simultaneously through the Queensland Principal Medical Officer.

Here the matter rests. Neither he nor I have received the slightest acknowledgement of our respective applications. The inertia of red tape is proverbial; but surely an appeal from a man who has done so well as my erstwhile partner should achieve some result; even a polite official refusal would be better than a complete ignoring. Perhaps the requests have been pigeon-holed by some understrapper at headquarters and have not been considered by real authority.

All honour to the men who have gone and have done their work in this big business—and among these my friend is not the least. Still, the condemnation of some who have not gone is undeserved. Shirkers there are, and always will be, and the Service is well rid of them; but there are some who are keen to "give up comfort and cash" for the honour of standing in the same ranks as the men of the A.N.Z.A.C. Medical Services who have seen it through up to now.

Yours, etc.,

HAROLD SOUTH.

"Dandenong," Park Street, Boonah,
Queensland, February 2, 1917.

LODGE-PRACTICE.

Sir,—In 1893 the local lodges signed an agreement with their surgeon. The rates ruling then have not been altered since. This year I asked for an increase. The reply was, it was impossible to give an increase. Impossible for a healthy man to pay more than 18s. for medical attendance! And in the suburbs it is 12s. 6d. and 14s. per annum. Why he pays his barber and tobacconist as much in a month. War work first, certainly, but isn't it reasonable to settle this inevitable question at once?

For these reasons: (*a*) It has to be settled, and there will be a fight. (*b*) Organization now is good, and the fight would be short and successful. (*c*) The medical men returning from the war will reap the benefit without the unpleasantness of the strife. (*d*) The present rates are ridiculous if compared with present cost of living. (*e*) A delay till after the war will inevitably cause strife and disunion in the profession. The true reason of delay is that a large section of the profession does not depend on contract practice for a living; but that should not affect the policy of the governing body. With apologies for trespassing on your valuable space, I close, sincerely trusting, Sir, that you will give the movement the support it deserves.

Yours, etc.,

"COUNTRY MED."

March 3, 1917.

THE ANÆMIAS.

Sir,—With regard to the points raised in the letter of "G.P." (*absit omen*), I should like to present the other side of the question. Admittedly there is little pathological work which the busy general practitioner can find leisure to do, but most emphatically I consider that examination of the blood should be done and can be done by him. Particularly is this so in the country, where the services of a pathologist are generally not available; and here also throat swabs and sputum examinations are most essential diagnostic methods, which should be used by every conscientious practitioner.

It is not very often that a blood examination is needed in general practice, and the time it consumes is not great. Even one who does it infrequently (like myself) can perform a blood count in a few minutes, and hæmoglobin values can be roughly, yet fairly accurately, estimated in a few seconds by a Tallqvist scale. Slides can be stained quickly and simply by tabloid preparations, and the differential leucocyte count is the only procedure which takes up much time.

Can a general practitioner give a reliable opinion on a blood examination? In my opinion, most certainly in most cases. If he is in doubt, say, in hunting for malarial parasites, he can transmit the slides to a pathologist. But it seems to me that the practitioner who does not make use of the blood count or film examination in practice is neglecting valuable aids to his art, and he who cannot recognize the more typical of the blood pictures, such as pernicious anæmia or the leukæmias, has failed to preserve that freshness in his work which is so essential to an up-to-date doctor.

In short, general practice and familiarity with the simpler branches of microscopic technique are not incompatible.

Yours, etc.,

"COUNTRY PRACTITIONER."

Obituary.

CHARLES CAMPBELL BAXTER TYRIE.

Charles Campbell Baxter Tyrie, whose death was announced in our issue of last week, was born at Moulin, near Pitlochry, in the Perthshire Highlands, 46 years ago. His father was engaged in business pursuits there. He came of a highly intellectual family, of which several members have made their mark in the world of learning. Two of his sisters hold high positions in the Department of Education in England. His early education was acquired locally, and, being Scotch, was thorough and individual. After leaving school he entered upon his medical studies at the Edinburgh University, and soon showed evidence of a keen intellect and of a great capacity for work. He secured a high place in his classes, and eventually graduated in 1892, obtaining second-class honours for the whole course. For about one year he held the position of Demonstrator of Anatomy at the Royal College of Surgeons. He then became Senior Demonstrator of Anatomy at Leeds, where he carried out a considerable amount of original work. Like many others, however, he soon discovered that teaching of anatomy carried with it small prospect of material advancement, and consequently he sought other fields for moulding his future career. He equipped himself for general practice by reviving his clinical knowledge at a post-graduate course, and by doing hospital work. He then entered into partnership with an established colleague at Keighley, in Yorkshire, and soon secured a position on the staff of the local hospital. Within a brief time he earned a considerable reputation as a surgeon.

While in Yorkshire he married, and his adventurous spirit led him to seek wider fields in Queensland. On his arrival in Australia he first accepted a position in the Queensland Department of Public Health, and later he practised in Boonah and Cairns. At Cairns he took a great interest in tropical diseases, but, unfortunately, he contributed but little to scientific literature. He was a general favourite, and speedily became a busy man. His innate enthusiasm forced him to apply his talents outside his professional sphere and to interest himself with the life of the place, engaging in many activities for the advancement of the town and district. At the same time he managed to reserve some leisure for his favourite pastimes of shooting and fishing.

Some little time after war had broken out he offered his services with the Expeditionary Force to German New Guinea, being already a surgeon in the Australian Navy. On his return he resumed civil practice, this time in New South Wales, but some little time before his death he had again donned His Majesty's uniform, with the intention of proceeding overseas in the service of his country.

He leaves a wife and five children. Two boys are in training for the Naval Service at home.

Medical Appointments.

It is announced in the *Queensland Government Gazette* of February 24, 1917, that Dr. Robert Allan Gordon Malcolm has been appointed Government Medical Officer at Blackall, in place of Dr. Paul Réné Loubet.

Dr. Andrew Davidson has been appointed Official Visitor to the Licensed House for the Insane at Cook's River, known as Bay View House (New South Wales), during the absence on leave for six months of Dr. S. A. Smith.

* * * * *

In the *Commonwealth of Australia Gazette* of February 23, 1917, notice is given that the following have been appointed a Board of Censors to exercise the powers conferred by the Customs (Cinematograph Films) Regulations, 1917, and such other powers in relation to the censorship of cinematograph films imported into the Commonwealth of Australia for exhibition as may be delegated to them:—

Sir H. N. P. Wollaston, K.C.M.G., I.S.O., LL.D., J.P.
Archibald, T. Strong, Esquire, M.A.
J. H. L. Cumpston, M.D., D.P.H., Director of Quarantine.

* * * * *

Dr. A. S. McIntosh has been appointed Acting Health Inspector to the Fremantle District Road Board in place of Dr. F. G. Easton, deceased.

* * * * *

Dr. R. D. Kennedy has been appointed Medical Officer of Health to the Kellerberrin District Road Board, Western Australia.

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In pursuance of the provisions of Section 2 of the *Midwives Act*, 1916, No. 2887, Dr. William Ernest Jones and William Alfred Callaway, Esq., have been appointed additional Members of the Midwives Board, Victoria.

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The appointment of Dr. G. A. T. Haydon in place of Dr. C. A. Courtney (resigned) as Officer of Health, Ballaarat Shire, has been approved

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Dr. A. T. Langley has been recommended for appointment as Public Vaccinator for the Metropolitan District at Ferntree Gully, Victoria.

* * * * *

Dr. John Talbot Brett has been appointed Public Vaccinator for the Metropolitan District, Melbourne (Calf Lymph Depôt).

* * * * *

Dr. Henry Cecil Colville, of Brighton, has been appointed Medical Superintendent of the Alfred Hospital.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xxi.

Brisbane Hospital, Junior Resident Medical Officers.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United F.S. Institute
SOUTH AUSTRALIA. (Hon. Sec., 8 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
WESTERN AUSTRALIA. (Hon. Sec., 230 St. George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn, and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	F.S. Lodges, Wellington, N.Z.

Diary for the Month.

Mar. 13.—N.S.W. Branch, B.M.A., Ethics Committee.
Mar. 13.—Tas. Branch, B.M.A., Council and Branch.
Mar. 15.—Vic. Branch, B.M.A., Council.
Mar. 15.—N.S.W. Branch, B.M.A., last day for Nomination of Candidates for Election of Council of Branch.
Mar. 16.—Q. Branch, B.M.A., Council.
Mar. 20.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
Mar. 21.—W. Aust. Branch, B.M.A., General.
Mar. 27.—N.S.W. Branch, B.M.A., Medical Politics Committee; Organization and Science Committee.
Mar. 28.—Vic. Branch, B.M.A., Council.
Mar. 29.—N.S.W. Branch, B.M.A., Return of Ballot Papers for Election of Council of Branch.
Mar. 29.—S. Aust. Branch, B.M.A., Branch.
Mar. 30.—N.S.W. Branch, B.M.A., Annual Meeting.
Apr. 3.—N.S.W. Branch, B.M.A., Council (Election of Officers and appointment of Standing Committees).
Apr. 4.—Vic. Branch, B.M.A., Branch.
Apr. 6.—Q. Branch, B.M.A., Branch.
Apr. 10.—N.S.W. Branch, B.M.A., Council (Quarterly).
Apr. 10.—Tas. Branch, B.M.A., Council and Branch.

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

The Medical All communications should be addressed to "The Editor," *Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.